

04964

Reg. Dist. No. 215

Reg. Dist. No. 215

22. I hereby certify that I attended the deceased from <u>May 29</u> , 19 <u>51</u> , to <u>May 30</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>51</u> , and that death occurred at <u>8:10 A</u> . m., from the causes and on the date stated above.			
SIGNATURE <u>S. R. Mills, Jr.</u>		ADDRESS <u>U.S. NAVAL HOSPITAL, BETHESDA, MD.</u>	
(Degree or title)		DATE SIGNED <u>May 31, 1951</u>	
S. R. MILLS, Jr., LTJG, MC, USN U.S. NAVAL HOSPITAL, BETHESDA, MD. May 31, 1951			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 5, 1951	Arlington National	Arlington, Virginia
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 31, 1951	<u>Edith W. Huntington</u>	W. E. Jarvis,	1432 U Street, NW, Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04965

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) _____		CITY (If outside corporate limits, write RURAL and give nearest town) _____	
TOWN _____		TOWN <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban General Bethesda MD.</u>		STREET ADDRESS (If rural, give location) <u>5059 Sargent Rd. N.E.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Dora</u>	(Middle) _____	(Last) <u>Allen</u>
4. DATE OF DEATH	(Month) <u>5</u>	(Day) <u>13</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) _____	8. DATE OF BIRTH <u>Feb 4, 1893</u>
9. AGE last birthday <u>58</u> yrs.	If under 1 year Months _____ Days _____	If under 24 hrs. Hours _____ Min. _____	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
11. BIRTH PLACE (State or foreign country) <u>Buffalo N.Y.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>John Wasniewski</u>	14. MOTHER'S MAIDEN NAME <u>Josephine</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT AND ADDRESS <u>Mrs. Teresa O'Dea - 5059 Sargent Rd. N.E.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebrovascular Accident

INTERVAL BETWEEN ONSET AND DEATH

3 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Arteriosclerotic Heart Disease10 yrs(c) Arteriosclerosis Generalized5 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	PLACE (Home, farm, factory, street, OF office bldg., etc.) _____	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 11-14-50, 19_____, to 5-13, 1951., that I last saw the deceased alive on 5-13-51, 19_____, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) _____	DATE THEREOF <u>5-14-51</u>	NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>	LOCATION (City, town, or county) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REG. <u>5-14-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Timothy Hanlon</u>	ADDRESS <u>641 H. ST. N.E.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1951
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital		STREET ADDRESS (If rural, give location) 9610 Sutherland Road	
3. NAME OF DECEASED (First) (Middle) (Last) James O. Baker		4. DATE OF DEATH (Month) (Day) (Year) May 30 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 2, 1864
9. AGE last birthday 87 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale Grocer, retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Trenton, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christian Baker		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Mrs. Gertrude L. Miller, 9610 Sutherland Rd.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION Silver Spring, Md.	
Immediate cause Circulatory collapse from shock of surgery and		INTERVAL BETWEEN ONSET AND DEATH	
(a) extensive bleeding		30 min.	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Hemorrhage from ruptured artery of lesser curvature	
124b		(c) of stomach	
		Congestive heart failure grade 2 - chronic	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Recurrent duodenal ulcers (one healing) Mild sclerosis of liver (laennac)	
19a. DATE OF OPERATION May 30, 1951		19b. MAJOR FINDINGS OF OPERATION none	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **OCT. 15, 1947**, to **MAY 30, 1951**, that I last saw the deceased alive on **MAY 30, 1951**, and that death occurred at **1:55 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Trans. & Burial		DATE THEREOF 6/5/51	NAME OF CEMETERY OR CREMATORY Green Mountain Cemetery	LOCATION (City, town, or county) (State) Boulder County Colorado
DATE REC'D BY LOCAL REG. 6/1/51		REGISTRAR'S SIGNATURE Bessie M. Thompson		24. FUNERAL DIRECTOR Wm. B. Humphrey, 8434 Ga. Ave., Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

BUREAU V. S.

JUN 4 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04967

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4910 Saratoga Ave.</u>		STREET ADDRESS (If rural, give location) <u>4910 Saratoga Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>Harold</u> (Last) <u>Bayne</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 22, 1897</u>
9. AGE last birthday <u>54</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. H. Bayne</u>		14. MOTHER'S MAIDEN NAME <u>?? Knott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-4909</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Hazel Bayne 4910 Saratoga Ave.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

sudden

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Congestive heart failure

1 day

(c) Coronary sclerosis

Indefinite

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypotension

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 9, 1950, to May 14, 1951, that I last saw the deceased

alive on May 13, 1951, and that death occurred at 4:40 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

F. M. McChesney M.D.

4620 36th St. NW

5/14/51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/15/51

Bessie M. Thompson

Chevy Chase Funeral Home

Chevy Chase - 5101 Wis. Ave. NW., DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MAY 22 1951

MARYLAND STATE DEPARTMENT OF HEALTH

04968

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Germantown, Md.</u> LENGTH OF STAY (in this place) <u>5 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laytonsville, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Germantown, Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Julia</u> (Middle) <u>Griffith</u> (Last) <u>Becraft</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>21</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>7/29/1875</u>
9. AGE last birthday <u>75</u> yrs.		10. If under 1 year (Months) <u>1</u> year (Days) <u>21</u> If under 24 hrs. (Hours) <u>19</u> (Min.) <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic-own home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Montgomery, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United Sts.</u>	
13. FATHER'S NAME <u>George Fenton Snouffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Morgan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Marshall Munce, York, Penn.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of transverse colon - generalized metastases</u>		<u>1 1/2 years</u>
Antecedent cause(s) (b) <u>153X</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>46e</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 14, 1951, to May 21, 1951, that I last saw the deceased alive on May 11, 1951, and that death occurred at 4:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James B. Kern M.D. ADDRESS Lamascus, Md. DATE SIGNED 5/21/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5/23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Laytonsville Md.</u>	LOCATION (City, town, or county) <u>Laytonsville Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>May 23, 1951</u>	REGISTRAR'S SIGNATURE <u>Abraham L. Cooke</u>	24. FUNERAL DIRECTOR <u>Roy W. Barber, Laytonsville, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. S.

MAY 28 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04969

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4001-East West Highway</u>		STREET ADDRESS (If rural, give location) <u>4001-East West Highway</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hannah</u> (Middle) <u>Etta</u> (Last) <u>Blair</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>4/23/1865</u>
9. AGE last birthday <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Grand Island, Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hurley</u>		14. MOTHER'S MAIDEN NAME <u>Nester Webb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>578-40-1778</u>	
17. INFORMANT <u>Mrs. Mabel B. Little</u>		(Daughter)	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>Immediate cause (a) <u>Cerebrovascular accident</u></p> <p>Antecedent cause(s) (b) <u>Gen'l. arteriosclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility</u></p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>No</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>No</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 6, 1951 to May 16, 1951, that I last saw the deceased alive on May 16, 1951, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>5/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Leis Crematorium</u>	LOCATION (City, town, or county) <u>Washington</u> (State) <u>DC</u>
DATE REC'D BY LOCAL REG. <u>May 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>John Lee Sons Co</u>	ADDRESS <u>300-4th NE</u>

290 656

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 17 1951
R. R. BAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04970
Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Virginia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park, Md.</u> LENGTH OF STAY (in this place) <u>37 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arlington Va.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hospital</u>		STREET ADDRESS (If rural, give location) <u>5111 No. 10th. St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>Spalding</u>	(Last) <u>Bonnell</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>18</u>	(Year) <u>1951</u>
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 22 1882</u>
9. AGE last birthday <u>68</u> yrs.		If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired gov. clerk.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Bonnell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Virginia Degges</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u> </u>	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>patient</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a)	<u>Coronary Occlusion</u>		<u>1 hr.</u>
420.1 Antecedent cause(s) (b)	<u>Hypertensive Heart Disease</u>		<u>5 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	<u>Cerebral atherosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS	<u>Involuntional melancholia</u>		<u>6 mths</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
<u>none</u>	<u>none</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
SUICIDE <u>none</u>	INJURY		(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 11, 1951, to May 18, 1951, that I last saw the deceased alive on May 18, 1951, and that death occurred at 11:55 a.m., from the causes and on the date stated above.

SIGNATURE C. K. Anderson MD. ADDRESS Washington Sanitarium Takoma Park DATE SIGNED 5-18-51

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 5-31-1951 NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery LOCATION (City, town, or county) Washington, D.C. (State)

DATE REC'D BY LOCAL REG. 5-4-51 REGISTRAR'S SIGNATURE J. H. Wilson M. FUNERAL DIRECTOR J. S. Dawler's Sons, Wash., D.C. ADDRESS

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

390916

RECEIVED
MAY 21 1961
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04971
Reg. Dist. No. 211

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Near Damascus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Near Damascus (Purdom)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. F. D. Monrovia,</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. Monrovia,</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Lula Blanche Brown</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 17, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 7, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Poole</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Burdette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Markin Day Monrovia, Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Cerebral Hemorrhage</u>	<u>8 days</u>
Antecedent cause(s)	(b) <u>Cardio-vascular-renal disease with Hypertension</u>	<u>15 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>Carcinoma - right breast. (?)</u>		<u>3 years ?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>--</u>	19b. MAJOR FINDINGS OF OPERATION <u>No operation</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE --	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? --

22. I hereby certify that I attended the deceased from May 10, 1951, to May 17, 1951, that I last saw the deceased alive on May 17, 1951, and that death occurred at 11:45 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>May 20, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>	LOCATION (City, town, or county) (State) <u>Purdom, Md</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>May 20, 1951 Della K. Burdette</u>		24. FUNERAL DIRECTOR <u>W. Barber Lexington, Va</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04972

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> TOWN <u>Cherry Chase</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Montgomery</u> COUNTY <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> TOWN <u>Cherry Chase</u> STREET ADDRESS (If rural give location) <u>102 East Underwood</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Henry</u> (Middle) <u>Burgess</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>24</u> (Day) <u>1957</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 21, 1872</u>
9. AGE last birthday <u>78</u> yrs. <u>6</u> Months <u>3</u> Days		10. If under 1 year <u>6</u> Months <u>3</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper - Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Elizabeth City N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Henry Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Martha Rebecca Newbold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>Newbold Burgess</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Congestive Heart Failure</u>	<u>1 1/2 yrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized Atherosclerosis</u>	<u>20 years</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>	INJURY OCCURRED While at <u>Work</u> Not While <u>At work</u>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug., 1946, to 5-24, 1957, that I last saw the deceased alive on 5-10, 1957, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE <u>Frederick B. Rude M.D.</u>		ADDRESS <u>3900 Military Rd. May 24, 1957</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>MAY 24, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>LOVLAINE</u>	LOCATION (City, town, or county) (State) <u>Wood LAWN, BALTO. Md.</u>
DATE REC'D BY LOCAL REG. <u>5/25/57</u>	REGISTRAR'S SIGNATURE <u>Dr. Rude</u>	24. FUNERAL DIRECTOR <u>John O. Mitchell</u>	ADDRESS <u>1900 Eutaw Pl.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

T

290726

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 7 on:

FILM No. G 133 MAY 21 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04973

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 104 Northwood Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wishart Talieferro Burroughs

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Divorced

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 18988. AGE: Years Months Days If less than one day
61 hrs. min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Guide - Masonic Temple

11. Industry or business

12. Name William Burroughs

13. Birthplace

14. Maiden name Taliaferro

15. Birthplace

16. Informant Hospital Records

Address

17. Burial Date thereof 5-14-51
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort LincolnLocation Pr. Georges Co Md.18. Funeral director The S. H. Jones Co.Address 2901 14th St. N.W. Wash. D.C.19. 5-12 19 51 Bessie M. Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May 19 51 at 2:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Cent. 19 51 to 10 May 19 51
and that I last saw him alive on 9 May 19 51

Immediate cause of death

Cerebral Hemorrhage

DURATION

9 days

Due to

Hypertension
arteriosclerosis

Due to

331X

Other conditions

83a

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William D. Caud, MD

M. D. or other

Address Silver Spring Md Date signed 10 May 51
751897

RECEIVED
MAY 14 1951
BUREAU K. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04974

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH- COUNTY Montg, MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montg	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Derwood, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) OR Gaithersburg. TOWN (If rural, give location) STREET ADDRESS Frederick Ave	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) Felicia (First) Girtrude (Middle) Bussard (Last)		4. DATE OF DEATH (Month) May (Day) 18/5 (Year) 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH June 22/1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Boarding House	9. AGE last birthday 68 yrs. 10/26
11. BIRTHPLACE (State or foreign country) House, Frederick Co, Md,		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thaddius T. Bussard		14. MOTHER'S MAIDEN NAME Ann Precilla Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Harry Bussard. Derwood, Md. Rural.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) acute heart failure, congestive		48 hrs
Antecedent cause(s) (b) fractured neck of femur		3 mos
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 3/1/51	19b. MAJOR FINDINGS OF OPERATION fm placed in fracture	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY 8-10-5-1951 m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR fell off chair at home

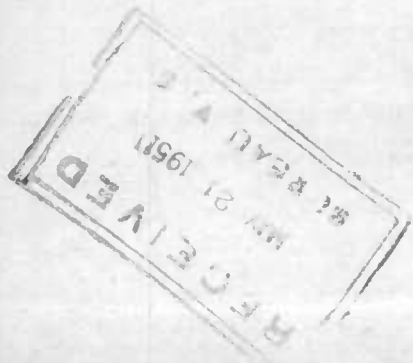
22. I hereby certify that I attended the deceased from 2-5-1951, to 5-18-1951, that I last saw the deceased alive on 5-18-1951, and that death occurred at 12:35 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) William C. Miller, M.D., 7-Brooks Ave., Gaithersburg, Md		ADDRESS DATE SIGNED 4/9/51	
23. BURIAL, CREMATION REMOVAL Burial	DATE 5/21/51	NAME OF CEMETERY OR CREMATORY Mt Olivet,	LOCATION (City, town, or county) Frederick, Md, (State)
DATE REC'D BY LOCAL REG. May 18, 1951	REGISTRAR'S SIGNATURE Wanda S. Brooke	24. FUNERAL DIRECTOR ADDRESS Ernest C. Gartner, Gaithersburg Md, 120526	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04975

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH - COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SPENCERVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SPENCERVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDWARD</u>	(Middle) <u>HASLER</u>	(Last) <u>CARR</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN. 26, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAIRY FARMER - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY OWNER</u>	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MONTGOMERY COUNTY, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CALEB CARR</u>		14. MOTHER'S MAIDEN NAME <u>MARY EMILY BURTON.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>CLARA CARR, SPENCERVILLE, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Chronic Intestinal Myopathy

INTERVAL BETWEEN ONSET AND DEATH

1 yr +

Antecedent cause(s)

(b)

Chronic Endocarditis1 yr

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 10/24, 1950, to 3/10, 1951, that I last saw the deceased alive on 5/10, 1951, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

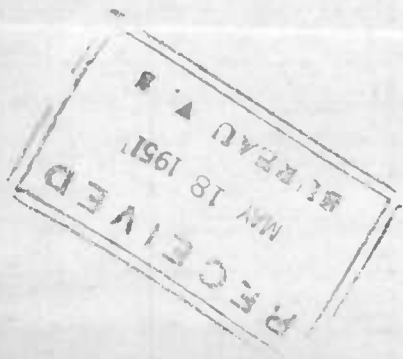
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>MAY 13, 1951</u>	<u>UNION CEMETERY</u>	<u>BURTONSVILLE, MONTG. Co.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>MAY 11 - 1951</u>	<u>Gertrude B. Lawler</u>	<u>Spencer Talbot</u>	<u>254 Carroll St. NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04976

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Pennsylvania COUNTY Philadelphia	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Philadelphia	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) Hotel Sylvania ✓	
3. NAME OF DECEASED (Type or Print) Mary (First) Elwell (Middle) CONDIT (Last)		4. DATE OF DEATH May 28, 19 51	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	9. AGE last birthday Approx 72 yrs.
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Executrix of estate: Mildred I. BROMLEY,		18. MEDICAL CERTIFICATION 620 Valley Street, Maplewood, New Jersey.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Pulmonary Edema, acute		10 hrs	
Antecedent cause(s) (b) Thrombosis, Coronary artery & massive		19 days	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) myocardial infarction			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 9 , 19 51 , to May 28 , 19 51 , that I last saw the deceased alive on May 28 , 19 51 , and that death occurred at 1:58 A.m. , from the causes and on the date stated above.			
SIGNATURE R. J. McCarthy		ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
DATE SIGNED May 29, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Cremation		DATE THEREOF May 29, 1951	
NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		LOCATION (City, town, or county) Suitland, Maryland	
DATE REC'D BY LOCAL REG. May 29, 1951		24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Maryland.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

04977

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>RFD #3</u>	
3. NAME OF DECEASED (Type or Print) <u>Lewia D. Conner</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>1</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>about 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jerry Conner</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Hospt. Records</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
454X Immediate cause (a) <u>Thrombosis abdominal aorta</u>		7 days	
99 Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4-30</u> , 19 <u>51</u> , to <u>5-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-1</u> , 19 <u>51</u> , and that death occurred at <u>12-01 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE (A. Gomez) M.D. <u>A. Gomez</u>		ADDRESS <u>Suburban Hospital</u> DATE SIGNED <u>5-1-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Potomac Chapel Cem.</u>	LOCATION (City, town, or county) (State) <u>Potomac, Md.</u>
DATE REC'D BY LOCAL REG. <u>5-1-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert G. Thompson</u> ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105

RECEIVED

MAY 3 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

04978

214

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8327 16th St.		STREET ADDRESS (If rural, give location) 8327 16th St.	
3. NAME OF DECEASED (Type or Print)	(First) Frances	(Middle) Cohea	(Last) Daly
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 17, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Peoria, Illinois
13. FATHER'S NAME Alfred J. Cohea		14. MOTHER'S MAIDEN NAME Nettie H. Hickman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-28-5062	17. INFORMANT AND ADDRESS 8327 16th St. Col. James E. Daly Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Myocardial infarct, anterior portion of intraventricular septum**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Arteriosclerotic coronary occlusion of anterior descending branch of left coronary artery.**(c) **artery.**

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that Staff Walker Reed Army Hosp attended the deceased from Feb. 1951, to May 4 1951, that they last saw the deceased alive on May 4 1951, and that death occurred at 12:15A.m. , from the causes and on the date stated above.		
SIGNATURE Vernon M. Smith	(Degree or title) Captain	ADDRESS Walker Reed Army Hosp. 7 May 51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/8/51	NAME OF CEMETERY OR CREMATORY Arlington National Cemetery
LOCATION (City, town, or county) Arington	(State) Va.	24. FUNERAL DIRECTOR Frances Potter Warner & Pumphrey
DATE REC'D BY LOCAL REG. 5/8/51	REGISTRAR'S SIGNATURE Frances Potter Warner & Pumphrey	ADDRESS 8434 Ga. Ave. Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Montgomery County Coroner notified and approved.

RECEIVED
MAY 21 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04979 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sakona Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sakona Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>318 Garland Avenue</u>		STREET ADDRESS (If rural, give location) <u>318 Garland Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>CORA</u> (First) <u>RICHEY</u> (Middle) <u>DAY</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 29, 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Anderson, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Richey</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jane Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>Mary D. Patterson, 318 Garland Ave. Sakona Park</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral thrombosis

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

2. nephritis1 wk.

(c)

Arteriosclerosis10+ yrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4, 1945, to May 8, 1951, that I last saw the deceasedalive on May 7, 1951, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-8-51J. Arthur WaltersJ. Arthur Walters, 234 Carroll St. 7thSakona Park, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

RECEIVED
MAY 9 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04980

Reg. Dist. No. **213**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montg	
CITY (If outside corporate limits, write RURAL and give nearest town) Rockville		CITY (If outside corporate limits, write RURAL and give nearest town) Rockville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Fayette St.		STREET ADDRESS (If rural, give location) 14 Fayette St	
3. NAME OF DECEASED (Type or Print) Grover (First)	Cleveland (Middle)	Day (Last)	4. DATE OF DEATH (Month) (Day) (Year) May 10 1951
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 2-27-1885
9. AGE last birthday 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter	10b. KIND OF BUSINESS OR INDUSTRY CARPENTER
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE E. DAY		14. MOTHER'S MAIDEN NAME SARAH H. PENN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No. 217-07-7953	
17. INFORMANT AND ADDRESS JOHN T. DAY		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cerebral hemorrhage			Found dead in bed.
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Chronic alcoholism			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		3 wks	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE Frank J. Bruchant M.D.		DATE SIGNED 5-10-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 12, 1951	
NAME OF CEMETERY OR CREMATORY Providence		LOCATION (City, town, or county) (State) Kemptown, Md.	
DATE REC'D BY LOCAL REG. 5-16-51		24. FUNERAL DIRECTOR W. L. Burdette Hyattstown Md.	

VS. A15A

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510246

RECEIVED
MAY 17 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04981

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Margaret</u> (Middle) <u>E</u> (Last) <u>Day</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <u>MARRIED</u> WIDOWED <u>DIVORCED</u> (Specify)	8. DATE OF BIRTH <u>3/19/1883</u>
9. AGE last birthday <u>68</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William J. Dronenburg</u>	14. MOTHER'S MAIDEN NAME <u>Margaret Rhoades</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Clarence D. Day</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage -

Antecedent cause(s)

(b) High arterial tension, myocardial insufficiency(c) Senility

INTERVAL BETWEEN ONSET AND DEATH

36 hrs.2 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>	(STATE) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>	INJURY OCCURRED While at Work <u>✓</u> Not While At work <u>□</u>	HOW DID INJURY OCCUR <u>—</u>		

22. I hereby certify that I attended the deceased from Feb. 13, 1951, to May 23, 1951, that I last saw the deceased alive on May 23, 1951, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 24, 1951Charles L. GropeClayton W. Barber Laytonville MdFrancis H. Barber

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>303 Wilson Lane</u>		STREET ADDRESS (If rural, give location) <u>303 Wilson Lane</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sue</u>	(Middle) <u>G.</u>	(Last) <u>Deane</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>2</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-11-1871</u>
9. AGE last birthday <u>79</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Owensboro, Kentucky</u>	
11. BIRTHPLACE (State or foreign country) <u>Owensboro, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DeWitt Clinton Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Bell Weir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Miss Anna R. Griffith-same as Item 2</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cornary Thrombosis</u>		<u>6-hrs</u>
Antecedent cause(s) (b) <u>Generalized arterio-sclerosis</u>		<u>years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>osteoporosis and compression fracture of several vertebrae</u>		<u>3+yrs.</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from March, 1950, to May 2, 1951, that I last saw the deceased alive on Apr 27, 1951, and that death occurred at 5- A m., from the causes and on the date stated above.

SIGNATURE George J. Miskant ADDRESS 2026 R St. N.W. - Wash. D.C. DATE SIGNED May 2-1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>5-8-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) <u>Suitland</u>	(State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>5/7/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR ADDRESS <u>Roberts A. Humphrey Bethesda, Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 9 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04983

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1717 Dublin Dr.</u>		STREET ADDRESS (If rural, give location) <u>1717 Dublin Dr.</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>Russell</u> (Last) <u>Dick</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 15, 1898</u> 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col. U. S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Dick</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I & II</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs. Genevieve S. Dick, 1717 Dublin Dr.</u>			

18. MEDICAL CERTIFICATION		<u>Silver Spring, Md.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Coronary occlusion</u>		<u>sudden death</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>9da</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Brorchart M.D.</u>		DATE SIGNED <u>5/11/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> LOCATION (City, town, or county) <u>Arlington, Va.</u> (State)	
DATE REC'D BY LOCAL REG. <u>May 14, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Silver Spring, Md.</u> ADDRESS	

Warner E. Pumphrey, Silver Spring, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

FILE NO. G 132 MAY 17 1951

04984

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

5612 Wisc. aveHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.City or town _____
(If outside city or town limits, write RURAL and give nearest town)Street No. 2407 Hinderbarger Place N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Johanna Bridgett Downing Downey

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) 12-18-59

8. AGE:

Years

91

Months

92

Days

28

If less than one day

hrs.

min.

9. Birthplace

Georgetown, Washington, D.C.
(Town, county, and state)

10. Usual occupation

unemployed

11. Industry or business

FATHER

12. Name

James Downing Downey

13. Birthplace

Ireland

MOTHER

14. Maiden name

Catherine Downing Downey

15. Birthplace

Ireland

16. Informant

Ada M. Brindshuff

Address

2407 Hinderbarger place N.W.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

5-14-51
(month) (day) (year)

Cemetery or crematory

Holy Road

Location

Wisc. ave. Wash. D.C.

18. Funeral director

Joseph J. Benck's Sons

Address

3034 M. St. N.W. Washington D.C.

19. (Date rec'd by registrar)

5-11-5119. 51Bessie M. Johnson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 19 51 at 930 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1949 19 51 to 5-8 19 51and that I last saw him alive on 5-8 19 51

Immediate cause of death

Myocardial degeneration

DURATION

24 hrs

Due to

Myocardial degeneration

Due to

4110x
92x

Other conditions

Sexuality

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Joseph R. Jordan M.D.

M. D. or other

Address 5612 Wisc. Ave NW Date signed 5/11/51

100

Washington

Washington

100

Washington

Johnston Island

Johnston Island

12-12-51

Johnston Island

Johnston Island

Johnston Island

BUREAU V. S.

RECEIVED
MAY 14 1951

MARYLAND STATE DEPARTMENT OF HEALTH

04985

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> STREET ADDRESS <u>Golden Lane - Rt #5</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>EVERETT</u> (Middle) <u>DOYING</u> (Last)		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>24</u> (Year) <u>1951</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>7/29/1881</u>	9. AGE last birthday <u>69</u> yrs.	10. If under 1 year Months Days Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER</u>		11. BIRTHPLACE (State or foreign country) <u>JACKSONVILLE ILL</u>	
13. FATHER'S NAME <u>GEORGE DOYING SR.</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE NORRIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>RAISINGTON MR GEO E DOYING JR MD</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X Immediate cause

(a)

Carcinoma of Lungs

INTERVAL BETWEEN ONSET AND DEATH

6 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1, 51, to May 24, 51, that I last saw the deceasedalive on May 22, 51, and that death occurred at 11:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/24/51Francis TellerJoseph Paulus Sons1756 P St. N.W.D.C.

036459

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04986

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u> LENGTH OF STAY (in this place) <u>115 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u> D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>4801 Connecticut Ave. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret</u> (First)	<u>Hardwicke</u> (Middle)	<u>Eacho</u> (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>May 17 1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>3-18-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William James Mayes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wolcott Handwicke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Washington San. Records - Takoma Park, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

223 x Immediate cause (a) <u>Inanition</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Perinatal</u>
56 d Antecedent cause(s) (b) <u>Subdural hemorrhage</u>	<u>2 mos.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Brain tumor, nonmalignant (5/28/51) (no) ?</u>	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>4-25-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Subdural hemorrhage + growth.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1951, to May 17, 1951, that I last saw the deceased alive on May 17, 1951, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

SIGNATURE Robert A. Hare, M.D. (Degree or title) ADDRESS Takoma Park, Md. DATE SIGNED 5/17/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>5/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Bryerview Cem</u>	LOCATION (City, town, or county) (State) <u>RICHMOND VA.</u>
DATE REC'D BY LOCAL REG. <u>5-12-51</u>	REGISTRAR'S SIGNATURE <u>F. Victor Dodd</u>	24. FUNERAL DIRECTOR <u>The A. H. Hines Co. 2801-14th St. N.W.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 21 1961
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

04987

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pa</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
TOWN <u>Bethesda</u>		TOWN <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>659 Hamilton St. N.W.</u>	
3. NAME OF DECEASED (First) <u>Elliott</u> (Middle) <u>Lee</u> (Last) <u>Edwards</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Gas light Co.</u>	8. DATE OF BIRTH <u>7-23-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>meter mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas light Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Edwardsville Va.</u>
13. FATHER'S NAME <u>Hiram Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Admonia Rodgers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Viola B. Edwards</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Gastro-intestinal hemorrhage, massive

INTERVAL BETWEEN ONSET AND DEATH

36 hours

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Post-operative hemorrhaging & diarrhea18 days(c) Cholecystitis & cholelithiasis, post-operative19 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>Apr. 16, 1951</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cholecystitis, acute & chronic & old perforation of gall bladder</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 1, 1951, to May 6, 1951, that I last saw the deceased alive on May 6, 1951, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>5-8-51</u>	NAME OF CEMETERY OR CREMATORY <u>Roseland Cem</u>	LOCATION (City, town, or county) <u>Readville Va</u>	(State)
DATE REC'D BY LOCAL REG. <u>5/7/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Deal Lunnie Home</u>	ADDRESS <u>4812 Ha Ave</u>	

554588 Wash D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 9 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04988

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>409 W. Montg. Ave.</u>		STREET ADDRESS (If rural, give location) <u>409 W. Montg. Ave.</u>	
3. NAME OF DECEASED (First) <u>CALEDONIA</u> (Middle) <u>GORDON</u> (Last) <u>ENGLAND</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 18, 1866</u>
9. AGE last birthday <u>84</u> yrs. <u>8</u> Months <u>28</u> Days		10. AGE last birthday If under 1 year If under 24 hrs. <u>8</u> Months <u>28</u> Days <u>8</u> Hours <u>19</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
12. BIRTHPLACE (State or foreign country) <u>Virginia</u>		13. CITIZEN OF WHAT COUNTRY? <u>US</u>	
14. FATHER'S NAME <u>Thomas C. Gordon</u>		15. MOTHER'S MAIDEN NAME <u>Lusie Bullard</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY No. <u>None</u>	
18. INFORMANT AND ADDRESS <u>Chas. E. England-Same as item #2</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage, left hemiplegia

Antecedent cause(s)

(b) Arteriosclerosis & hypertension
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(c) Overweight

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 hours
5 years
26 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

19a. none 19b. none

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED White at Work ☐ Not White At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from 1930, 19....., to May 16, 1951, that I last saw the deceasedalive on May 16, 1951, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 5-18-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Wm. R. Linticum, M.D. Rockville, Md.
20 May 1951 Rockville Union
Rockville, Md.
Robert A. Humphrey
Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04989

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH- COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Dist. of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		STREET ADDRESS (If rural, give location) <u>2032 Belmont Rd N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ella</u> (First) <u>AYTON</u> (Middle) <u>Espy</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3-4-75</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year Months <u>5</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government Clerk - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Blake B Espy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ayton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

157x Immediate cause

(a) Carcinoma of liver primary site unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cholecystitis with cholelithiasis(c) Possible Carcinoma of head of pancreas

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5-6, 1951, to 5-12, 1951, that I last saw the deceasedalive on 5-12, 1951, and that death occurred at 11:00 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. H. K. Munde M.D. Takoma Park 12, Md 5-13-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 15, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	LOCATION (City, town, or county) <u>Washington</u>	(State) <u>D.C.</u>
DATE RECD BY LOCAL REG. <u>5-13-51</u>	REGISTRAR'S SIGNATURE <u>J. M. Munde</u>	24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>	ADDRESS <u>254 Carroll St NW</u>	

390916

Washington 12, DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 10 1961
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04990

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>CALIFORNIA</u> COUNTY <u>LOS ANGELES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>GLENDALE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON SANITARIUM AND HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>544 NORTH ADAMS STREET</u>	
3. NAME OF DECEASED (Type or Print) <u>IRMA</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>7-11-96</u>
9. AGE last birthday <u>54</u> yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HOUSTON, TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>ALANZO CARMICHAEL</u>		14. MOTHER'S MAIDEN NAME <u>IDA PACE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records, WASH. SAN. & HOSP.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Carcinoma of urinary bladder & colon and

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) dead of pancreas(c) anastomosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-29, 1951, to 5-17, 1951, that I last saw the deceasedalive on 5-17, 1951, and that death occurred at 5:00 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. T. K. G. M. A. 504 Tulip Ave, Takoma Park 12, Md 5-17-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 5-18-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 24, 1951. Forest Lawn Cemetery, Glendale, Los Angeles, California
J. W. W. R. D. 254 Carroll St. N. W. D. C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 21 1961
BUREAU A. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> TOWN <u>2 weeks</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> TOWN <u>1317 Sheridan St. N.W.</u> STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Annie</u> (First) <u>(none)</u> (Middle) <u>Frank</u> (Last)	4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1957</u>	5. SEX <u>Female</u>	6. COLOR OR RACE <u>Hebrew</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>---</u>	8. DATE OF BIRTH <u>June 2/1895</u>	9. AGE last birthday <u>75</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Samuel Maben</u>	14. MOTHER'S MAIDEN NAME <u>Rose (unknown)</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS <u>Hospital Records.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Generalized Metastasis, Uremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of Stomach

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerosis, Diabetes Mellitus

19a. DATE OF OPERATION

Feb. 8, 1957

19b. MAJOR FINDINGS OF OPERATION

Carcinoma of Stomach

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 46, 1956, to May 10, 1957, that I last saw the deceased

alive on May 10, 1957, and that death occurred at 11:42 a.m., from the causes and on the date stated above.

SIGNATURE

Dr. J. H. D. D.

(Degree or title)

ADDRESS

1736 Columbia Rd NW Wash DC. May 1, 1957

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial
DATE REC'D BY LOCAL REG. 5-12-57

DATE THEREOF

5-12-57

NAME OF CEMETERY OR CREMATORY

George Washington Cemetery

LOCATION (City, town, or county)

MD.

(State)

DATE REC'D BY LOCAL REG. 5-12-57

REGISTRAR'S SIGNATURE

J. H. D. D.

24. FUNERAL DIRECTOR

B. Dargansky

ADDRESS

3501 14th St NW Wash. DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

RECEIVED
MAY 15 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04992

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montg. County Gen. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Silver Spring, Md. Rt. 2</u>	
3. NAME OF DECEASED (Type or Print) <u>William R. Graybill</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 24, 1884</u> yrs. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployment</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sanitary</u>	
11. BIRTHPLACE (State or foreign country) <u>Frankfort, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry H. Graybill</u>		14. MOTHER'S MARRIAGE NAME <u>Mary W. Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>770888</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Coronary thrombosis8 days

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 12, 1951, to May 25, 1951, that I last saw the deceasedalive on May 25, 1951, and that death occurred at 6:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. D. Brumfield M.D.Sandy Spring Md5/25/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-28-51</u>	NAME OF CEMETERY OR CREMATORY <u>Recess family cem</u>	LOCATION (City, town, or county) <u>Johnson City Tenn</u>	(State) <u>Tenn</u>
DATE REC'D BY LOCAL REG <u>May 25-51</u>	REGISTRAR'S SIGNATURE <u>Esther B. Zander</u>	24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>	ADDRESS <u>254 Carroll St. NW</u>	

770888 Washington DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death are especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04993

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5115 Jammetown Rd.</u>		STREET ADDRESS (If rural, give location) <u>5115 Jammetown Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Howard</u> (Middle) <u>Blackburn</u> (Last) <u>YUPS</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>3-19-1910</u>
9. AGE last birthday <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Manager</u>	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Motors</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel B. Yunk</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>war II</u>		16. SOCIAL SECURITY No. <u>522-38-2723</u>	
17. INFORMANT AND ADDRESS <u>Margaret Yunk (wife)</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Coronary occlusion</u>			<u>sudden death</u>
Antecedent cause(s) (b) <u>420.1</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>940</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank B. Brockett M.D.</u>		DATE SIGNED <u>5-6-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>May 6/1957</u>	NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>
DATE REC'D BY LOCAL REG. <u>5-6-57</u>		REGISTRAR'S SIGNATURE <u>Bessie E. Thompson</u>	24. FUNERAL DIRECTOR <u>J.W. Lee & Sons Co.</u>
		ADDRESS <u>200-4th St. N.E.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04994

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8212 Nolte Ave.		STREET ADDRESS (If rural, give location) 8212 Nolte Ave.	
3. NAME OF DECEASED (Type or Print) RALPH	(First) R (Middle)	(Last) Gwin	4. DATE OF DEATH (Month) May (Day) 7 (Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 27, 1895
9. AGE last birthday 56 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Technician		10b. KIND OF BUSINESS OR INDUSTRY Dental Laboratory	
11. BIRTHPLACE (State or foreign country) Sunrise, Virginia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME David F. Gwin		14. MOTHER'S MAIDEN NAME Minnie Lockridge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 579-18-2583	
17. INFORMANT AND ADDRESS Mrs. Maude L. Gwin, 8212 Nolte Ave.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

11 Months

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 26, 1950**, to **May 7, 1951**, that I last saw the deceasedalive on **May 7, 1951**, and that death occurred at **9:30 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)
BurialDATE THEREOF
5/11/51NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county)
Arlington National Cemetery Arlington Va.DATE REC'D BY LOCAL
REG. **5/11/51**

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Francis J. Tetter **Warren E. Humphrey, 8434 Georgia Ave. Silver Spring, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 10 1961
BUREAU A.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04995

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Late Residence</u>		STREET ADDRESS (If rural, give location) <u>402 Warwick Place</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Susan</u> (Middle) <u>Louella</u> (Last) <u>Hackett</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>22</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 14, '62</u>
9. AGE last birthday <u>88</u> yrs.		10. If under 1 year: Months <u>10</u> Days <u>8</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>	
11. BIRTHPLACE (State or foreign country) <u>Ottawa, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jackson Shaver</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ruffner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>E. Turlington-son-in-law</u>		18. same as item 2	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Respiratory Failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Cerebral Hemorrhage</u>	<u>12 hours</u>
83a (c) <u>Chronic Heart failure & Pulmonary edema</u>	<u>3 mo</u>

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/20, 1951, to 5/22, 1951, that I last saw the deceased alive on 5/22, 1951, and that death occurred at 11:30 A. m., from the causes and on the date stated above.

SIGNATURE <u>Frank Y. Jagger, Jr. M.D.</u>	ADDRESS <u>5707 Wisconsin Ave. Chevy Chase Md</u>	DATE SIGNED <u>5/22/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>5-23-51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>
LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>
DATE REC'D BY LOCAL REG. <u>5/23/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

AY 44 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04996

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md.</u> COUNTY <u>Mont</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
TOWN <u>Takoma Park</u>		TOWN <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 Baltimore Avenue</u>		STREET ADDRESS (If rural, give location) <u>217 Baltimore Avenue</u>	
3. NAME OF DECEASED (First) <u>ELIZA</u> (Middle) <u>CATHERINE</u> (Last) <u>HANSLEY</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 8, 1873</u>
9. AGE last birthday <u>78</u> yrs.		10. UNDER 1 year (Months) <u>1</u> (Days) <u>19</u> (Hours) <u>19</u> (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon Yantzer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kline</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Virginia M. Dieringer, 217 Baltimore Ave., Tak. Park, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Thrombosis6 daysAntecedent cause(s) (b) Cerebral Arteriosclerosis20 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 14, 1951, to May 19, 1951, that I last saw the deceased alive on May 18, 1951, and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF SEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BuriedMay 22, 1951Oak Grove Cem.FogonOhio5-19-51J. Milton DoddJ. Arthur Walters254 Carroll St. Md.Takoma Park, D.C.

RECEIVED
MAY 24 1931
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04997
Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Olney</u> LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u> STREET ADDRESS (If rural, give location) <u>20 Summit Ave.</u>	
3. NAME OF DECEASED (Type or Print) MARY (First) ELLEN (Middle) HARDING (Last)		4. DATE OF DEATH May 10, 1951 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 11, 1878
9. AGE last birthday 72 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James T. Howard		14. MOTHER'S MAIDEN NAME Ruth R. Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Wm.C.Harding - Same as item #2			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Dissecting Aneurysm</u>	26 hours	
Antecedent cause(s) (b) <u>Atherosclerosis Arteriosclerosis</u>	Years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Degenerative Heart Disease</u>	Year	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1950, to May 10, 1951, that I last saw the deceased alive on May 9, 1951, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

SIGNATURE <u>Josh Schumacher M.D.</u>		ADDRESS <u>Gaithersburg, Md.</u>		DATE SIGNED <u>May 10, 1951</u>
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE <u>5/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	LOCATION (City, town, or county) <u>Gaithersburg, Maryland</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5-11-51</u>	REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	24. FUNERAL DIRECTOR <u>Robert H. Cunningham</u>	ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 18 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04998

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Olney		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Brooke Grove Farm Convalescent Home		STREET ADDRESS 1380 Peabody St., N. W.	
3. NAME OF DECEASED (Type or Print) Lenore (First)		4. DATE OF DEATH May 9, (Month) (Day) (Year) 1951	
5. SEX Female		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Dec. 27, 1879	
9. AGE last birthday 71 yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Cedar County, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Long		14. MOTHER'S MAIDEN NAME Octavia Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS 1380 Peabody St., N.W.		18. MOTHER'S MAIDEN NAME Mrs. Chas. P. Dake, Washington, D. C.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Insufficiency	4 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension & coronary artery heart disease	at least 2 years.
	(c) Cerebral thrombosis due to arteriosclerosis	one month
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 17**, 1951, to **May 9**, 1951, that I last saw the deceased alive on **May 8**, 1951, and that death occurred at **7:05 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Trans. & Burial	DATE THEREOF 5/12/51	NAME OF CEMETERY OR CREMATORY ?	LOCATION (City, town, or county) (State) Hudson, Lincoln County, South Dakota
DATE REC'D BY LOCAL REG. 5-12-51	REGISTRAR'S SIGNATURE Gertrude B. Lawler	24. FUNERAL DIRECTOR Wm. E. Humphrey	ADDRESS 8434 Georgia Ave. Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A10-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04999
Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>12205 Dewey Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) <u>Princeton</u> (Last) <u>Hawley</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>26</u> (Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>10-7-89</u>
9. AGE last birthday <u>61</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk - See Cream Counters</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>Stewart F. Hawley</u>	14. MOTHER'S MAIDEN NAME <u>Leota Elizabeth Light</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>213-14-3493</u>	17. INFORMANT AND ADDRESS <u>Donald R. Hawley (son) Perryville, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>2 day</u>
Antecedent cause(s) (b) <u>Arteriosclerosis, Generalized</u>			<u>yr.</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/24/51</u> , 19....., to <u>5/26/51</u> , 19....., that I last saw the deceased alive on <u>5/26/51</u> , 19....., and that death occurred atm., from the causes and on the date stated above.			
SIGNATURE <u>Donald R. Hawley</u>		ADDRESS <u>Mr. Hewington Rd 5/26/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-30-1951</u>	<u>Wear Creek Harmony</u>	<u>Wilmington, Rural, Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5-31-51</u>	<u>Bessie M. Thompson</u>	<u>W. A. Patterson & Son</u>	<u>390671 Perryville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05000

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>3260 Scott Place, N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) (Middle) <u>(none)</u> (Last) <u>HAZELOCK</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 4, 1898</u>
9. AGE last birthday <u>52</u> yrs. <u>08</u> Months <u>12</u> Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>On Pension</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>On Pension</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Auto Driver</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
13. FATHER'S NAME <u>Frank HAZELOCK</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte CARTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war, or dates of service) <u>WW I</u>		17. INFORMANT AND ADDRESS <u>Wife: Frances E. HAZELOCK, 939 E Street, SW, Washington, D.C.</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		18. MEDICAL CERTIFICATION <u>SW, Washington, D.C.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>diabetic acidosis</u>			<u>3 days</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>diabetes mellitus</u>			<u>11 years</u>
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 15</u> , 19 <u>51</u> , to <u>May 16</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>51</u> , and that death occurred at <u>8:55 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>S. R. Mills, Jr.</u> (Degree or title)		ADDRESS <u>U.S. NAVAL HOSPITAL, BETHESDA, MD.</u> DATE SIGNED <u>May 17, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>
LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
DATE REC'D BY LOCAL REG. <u>May 17, 1951</u>		24. FUNERAL DIRECTOR <u>W. E. Jarvis Funeral Home, 1432 U St., N.W., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

JGH 683WV

RECEIVED
JAN 21 1950
U.S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05001

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dickerson, Md. BFD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dickerson - BFD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George Otis Holland</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 2 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 13 - 1874</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired State Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John T. Holland</u>		14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Fox Holland, Dickerson</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Uremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes, Arteriosclerotic heart disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from August, 1950, to May 2, 1951, that I last saw the deceasedalive on May 1, 1951, and that death occurred at 4:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

<u>Burial</u>	<u>May 5/51</u>	<u>Monocacy</u>	<u>Beallsville, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 3/51</u>	<u>Charles E. Egan</u>	<u>William B. Hilton</u>	<u>Barnesville, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05002

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium + Hospital</u>		STREET ADDRESS (If rural, give location) <u>3012 Channing St. N.E.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u>	(Middle) <u>William</u>	(Last) <u>Holt</u>
4. DATE OF DEATH	(Month) <u>5</u>	(Day) <u>29</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-25-90</u>
9. AGE last birthday <u>60</u> yrs.	If under 1 year Months <u>5</u> Days <u>29</u>	If under 24 hrs. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't worker, clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Washington Holt</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Osborne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. (If yes, give war or dates of service) <u>WWI</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cachexia</u>			<u>months</u>
Antecedent cause(s) (b) <u>Carcinoma of pancreas</u>			<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/13</u> , 19 <u>51</u> , to <u>5/29</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/28</u> , 19 <u>51</u> , and that death occurred at <u>2:45 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frederic Breunel M.D. Takoma Park</u>		DATE SIGNED <u>5/29/51</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>June 1-1951</u>		NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>	
LOCATION (City, town, or county) <u>St. George's</u>		(State) <u>Ind.</u>	
DATE REC'D BY LOCAL REG. <u>5/29/51</u>		24. FUNERAL DIRECTOR <u>Alvin Co</u> ADDRESS <u>2901-14th St. N.W.</u>	

390916 Wash D.C.

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05003

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE New York COUNTY Oneida	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Utica	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		STREET ADDRESS (If rural, give location) 1600 Sunset Street	
3. NAME OF DECEASED (Type or Print) Harry	(First) Van	(Last) HOPKINS	4. DATE OF DEATH (Month) (Day) (Year) May 9, 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 2, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Cosmetics	9. AGE last birthday 72 yrs.
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Arthur S. M. HOPKINS		14. MOTHER'S MAIDEN NAME Inez VANDYKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Son: Gerald A. HOPKINS		18. MEDICAL CERTIFICATION 5612 North Capitol St., Wash., D.C.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause Chronic fibrosing pneumonitis with			
Antecedent cause(s) Cor pulmonale			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last 7 mos			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 9, 1951 , to May 9, 1951 , that I last saw the deceased alive on May 9, 1951 , and that death occurred at 4:15 P.m. , from the causes and on the date stated above.			
SIGNATURE S. W. EYER		ADDRESS U.S. NAVAL HOSPITAL	
DATE SIGNED May 10, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 12, 1951	
NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR S. H. Hines Funeral Home, 2901 14th Street, NW, Washington, D.C.			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAY 11 1951
BUREAU V

4-51-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05004

Reg. Dist. No. 223.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> TOWN <u>Takoma Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> TOWN <u>Takoma Park</u> STREET ADDRESS (If rural, give location) <u>302 Carroll Ave</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Hopping</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>21</u> (Year) <u>1951</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>8-19-75</u>	9. AGE last birthday <u>75</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Norfolk Virginia</u>			
13. FATHER'S NAME <u>Un Known Office</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Eisenbise</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Washington Sanitarium and Hospital record</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH		
Immediate cause (a) <u>Coronary Heart Failure</u>					<u>3 Day</u>		
Antecedent cause(s) (b) <u>Arteriosclerosis Benign</u>					<u>yr</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/20/51</u> , 19....., to <u>5/21/51</u> , 19....., that I last saw the deceased alive on <u>5/21/51</u> , 19....., and that death occurred at <u>10:45</u> m., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(Degree or title)		ADDRESS <u>Kensington Rd</u> DATE SIGNED <u>5/21/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 24, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> LOCATION (City, town, or county) <u>Washington D.C.</u>			
DATE REC'D BY LOCAL REG. <u>5-12-51</u>		REGISTRAR'S SIGNATURE <u>J. Wilson</u>		24. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St NW</u> ADDRESS <u>Wash. D.C.</u>			

RECEIVED
JUN 24 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05005

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>2 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> TOWN STREET ADDRESS (If rural, give location) <u>615 W. Montgomery</u>	
3. NAME OF DECEASED (Type or Print) <u>Erma</u> (First) <u>S.</u> (Middle) <u>Hoskinson</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>20</u> (Day) <u>1951</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-16-1890</u>	9. AGE last birthday <u>60</u> yrs. <u>7</u> Months <u>5</u> Days	If under 1 year If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboratory Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Phys. Off.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles T. Stearn</u>		14. MOTHER'S MAIDEN NAME <u>Ida Bell Slater</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Not Known</u>		17. INFORMANT AND ADDRESS <u>same as H. Harry Hoskinson-Husband- item 2</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

30 hours

Antecedent cause(s)

(b)

Arteriosclerosis10 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct, 1946, to 20 May, 1951, that I last saw the deceasedalive on 19 May, 1951, and that death occurred at 5:25 Am., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-22-51</u>	NAME OF CEMETERY OR CREMATORY <u>Potomac Chapel</u>	LOCATION (City, town, or county) <u>Potomac</u>	(State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>5-21-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>	

095868

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05006

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u> TOWN <u>Wheaton, Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12007 Ga. ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Montgomery</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u> TOWN <u>Wheaton, Md.</u> STREET ADDRESS (If rural, give location) <u>12007 Ga. ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles S. Hyson</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 2, 1858</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboat</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>93</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Hyson</u>		14. MOTHER'S MAIDEN NAME <u>Harrett unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>George Hyson</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Infarction

INTERVAL BETWEEN ONSET AND DEATH

few minutes

Antecedent cause(s)

(b)

Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Cardiorenal Disease

15 to 20 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

arthritis & Spinal Kyphosis

30 years

19a. DATE OF OPERATION none 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>X</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u>	(CITY OR TOWN) <u> </u>	(COUNTY) <u> </u>	(STATE) <u> </u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Also treated June to Sept 1937</u>		

22. I hereby certify that I attended the deceased from May 9, 1951 to May 9, 1951, that I last saw the deceased alive on May 9, 1951, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Webster Savell, M.D.

Norbeck Rd

May 12, 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/13/51</u>	NAME OF CEMETERY OR CREMATORY <u>Wheaton</u>	LOCATION (City, town, or county) <u>Wheaton, Md.</u>	(State) <u> </u>
-------------------------------------------------------	---------------------	----------------------------------------------	------------------------------------------------------	-------------------

DATE REC'D BY LOCAL REG. <u>May 14, 1951</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Robert L. Sawade</u>	ADDRESS <u> </u>
----------------------------------------------	---------------------------------------------	----------------------------------------------	-------------------

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

05007

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 3903 Queensbury Road	
3. NAME OF DECEASED (Type or Print)	(First) Adrian	(Middle) Charles	(Last) JAMES
4. DATE OF DEATH	(Month) May	(Day) 31,	(Year) 19 51
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec. 2, 1950
9. AGE last birthday 00 yrs.		10. MONTHS 05 DAYS 29 Hours 05 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Alfred R. JAMES		14. MOTHER'S MAIDEN NAME Catherine MOCKUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Mother: Catherine M. JAMES			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

752X Immediate cause (a) **Hydrocephalus, Congenital**

157a Antecedent cause(s) (b) **Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last**

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **May 30**, 19**51**, to **May 31**, 19**51**, that I last saw the deceasedalive on **May 31**, 19**51**, and that death occurred at **11:00A** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

L. W. SEDERSTROM, LT, MC, USN**U.S. NAVAL HOSPITAL, BETHESDA, MD.****1 June 1951**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4 June 1951	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) Arlington, Virginia	(State)
-------------------------------------------------------	---------------------------------	---------------------------------------------------------	-------------------------------------------------------------	---------

DATE REC'D BY LOCAL REG. **June 1, 1951**

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 1, 1951**W. W. Chambers, 5801 Cleveland Ave.,****Riverdale, Maryland**

201020312 383

561

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

05008

1. PLACE OF DEATH COUNTY <u>Mont</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Washington</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Springs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>W.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>818 Sligo ave.</u>		STREET ADDRESS <u>517-8th St S.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Call John Jensen</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 7/1861</u>
9. AGE last birthday <u>89</u> yrs.		10. AGE last birthday If under 1 year: Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. W.E. Ridgeway, 818 Sligo ave</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Ventricular Fibrillation</u>		<u>6 hrs.</u>	
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>		<u>10 yrs.</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary Thrombosis</u>		<u>2 days</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 1</u> , 19 <u>51</u> , to <u>May 3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>51</u> , and that death occurred at <u>9:30 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>L.B. Snow M.D.</u>		ADDRESS <u>Silver Spring, Maryland</u>	
DATE SIGNED <u>5/3/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
FUNERAL DIRECTOR		ADDRESS	
<u>May 4/51</u>		<u>Francis Potter</u>	
<u>The S N News Co 2901-14th St NW</u>		<u>390916 Wash. W.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05009

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garrett Pk. Estates</u>		STREET ADDRESS <u>4935 E St., S.E.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Silas</u>			<u>Johnson</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Mar. 28, 1899</u>
9. AGE last birthday <u>52</u> yrs.		4. DATE OF DEATH <u>May 19</u>	(Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Laborer</u>		<u>House Project</u>	<u>Virginia</u>
13. FATHER'S NAME <u>Charles Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emily Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>578-05-4871</u>	
<u>no</u>		17. INFORMANT AND ADDRESS <u>Sadie L. Johnson (wife)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary occlusion</u>		<u>Sudden death</u>
Antecedent cause(s) (b) <u>420.1</u> Disease or condition, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE James J. Broesehart M.D. ADDRESS Garthman Md DATE SIGNED 5-19-51

23. BURIAL CREMATION REMOVAL (Specify) Burial DATE THEREOF 5/22/51 NAME OF CEMETERY OR CREMATORY Woodlawn LOCATION (City, town or county) Washington D.C. (State)

DATE REC'D BY LOCAL REG. 5-22-51 REGISTRAR'S SIGNATURE Helen S. Eckenfelder 24. FUNERAL DIRECTOR Robert L. Snowden, Rockville ADDRESS Rockville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970246 md.

RECEIVED

MAY 21 1951

MONTCOMERY COUNTY
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05010

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Colesville, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jolliffs Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>733 Thayer Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edward</u>	(Middle) <u>D.</u>	(Last) <u>Jones</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>26</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 2, 1861</u>
9. AGE last birthday <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Llewellyn D. Jones</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah E. McCarthy</u>		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Guy L. Jones 1902 Rosewood Rd. S. S.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic Heart Disease

Antecedent cause(s)

(b) Generalized arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Benign prostatic Hypertrophy

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

?

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/28/50, 19....., to 5/26/51, 19....., that I last saw the deceasedalive on 5/25/51, 19....., and that death occurred at 12:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 30, 1951 Frances Potter9601 Sutton Place
Silver Spring, Md.
May 26, 1951
Edw. C. Humphrey, Silver Spring, Md.

501817

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1951
BUREAU N. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

05011

1. PLACE OF DEATH- COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) OLNEY		CITY (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS THE MONTGOMERY COUNTY GENERAL HOSPITAL, INC.		STREET ADDRESS R# 2 (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) JOHN (Middle) Thomas (Last) JONES	4. DATE OF DEATH	(Month) MAY (Day) 28 (Year) 1951
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 9/4/1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired CARPENTER - Construction Co.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 86 yrs.
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ISAAC JONES		14. MOTHER'S MAIDEN NAME VIRGINIA SULLIVAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS HOSPITAL RECORDS			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) **Hemorrhage (Rectal)**
(b) **Carcinoma of Sigmoid**
(c)

INTERVAL BETWEEN ONSET AND DEATH

Shown
8.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) INJURY PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5/27**, 19**51**, to **5/28**, 19**51**, that I last saw the deceased alive on **5/28**, 19**51**, and that death occurred at **10 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5-31-51	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) (State) Quintland Md
DATE REC'D BY LOCAL REG. 6-28-51	REGISTRAR'S SIGNATURE Gertrude B Fowler	24. FUNERAL DIRECTOR W.W. Chambers Co	ADDRESS Wash. D.C.

570246

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05012

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) No 1 Lookout Green, S.W.	
3. NAME OF DECEASED (Type or Print) Michael Thomas KAY		4. DATE OF DEATH May 28, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 21, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Petty Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	9. AGE last birthday 00 yrs. 00 Months 07 Days
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Robert L. KAY		14. MOTHER'S MAIDEN NAME Mary Jane MARTIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT AND ADDRESS Father: Robert L. KAY			

18. MEDICAL CERTIFICATION **Same as item # 2**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

776X Immediate cause
Antecedent cause(s)
159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Immaturity due to*
(b) *Prematurity*
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **May 21, 1951**, to **May 28, 1951**, that I last saw the deceased alive on **May 28, 1951**, and that death occurred at **12:17 A.m.**, from the causes and on the date stated above.

SIGNATURE *A. G. Cannon* (Name or title)

ADDRESS

DATE SIGNED

A. G. CANNON, LTJG, MCR, USNR U.S. NAVAL HOSPITAL, BETHESDA, MD. May 28, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF June 1, 1951		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG. May 28, 1951		REGISTRAR'S SIGNATURE <i>Edna Whittington</i>		24. FUNERAL DIRECTOR Robert A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Maryland.		ADDRESS	

205211234240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 31 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
TOWN <u>10,000 GEORGIA AVE</u>		TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>10,000 GEORGIA AVE</u>		<u>2127 BOLTON ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>HARRY</u>	<u>GRANT</u>	<u>KEENER</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>NOV. 3, 1899</u>
9. AGE last birthday <u>51</u> yrs.		10. DATE OF DEATH <u>MAY 16 1951</u>	11. BIRTHPLACE (State or foreign country) <u>STRASBURG VA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>HECTOR B KEENER</u>	
14. MOTHER'S MAIDEN NAME <u>MARY PANLEY OWENS.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY No. <u>UNKNOWN</u>		17. INFORMANT <u>RUSSIA</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

196X Immediate cause

(a) SARCOMA OF FEMUR (RIGHT)

55X Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ACUTE MYOCARDITIS

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/7, 1951, to 5/16, 1951, that I last saw the deceased alive on 5/16, 1951, and that death occurred at 7:55 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

may 17, 1951

Frances Potter

Chas. H. Hines Co. 2901 14th St N.W.

VA.

690336 WASHINGTON D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 21 1951
LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05014 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Patuxent River</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>U.S. Naval Air Station</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>MEMQ No. 793-A</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Patricia</u> (Middle) <u>Ann</u> (Last) <u>KINCAID</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr 26, 1948</u>
9. AGE last birthday <u>03</u> yrs. <u>00</u> months <u>05</u> days		10. If under 1 year (Month) (Day) (Year)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Leslie M. KINCAID</u>		14. MOTHER'S MAIDEN NAME <u>Rosalee HUNT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Father: Leslie M. KINCAID</u>			

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pneumonia, Atypical

587.2 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
128 (c) Cystic Fibrosis of Pancreas

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr 26, 1951, to May 1, 1951, that I last saw the deceased alive on May 1, 1951, and that death occurred at 5:15 P.m., from the causes and on the date stated above.

SIGNATURE L. W. SEDERSTROM (Degree or title) ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED May 2, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>May 2, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Pine Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hillsboro, N. Hampshire</u>
DATE REC'D BY LOCAL REG <u>May 2, 1951</u>	REGISTRAR'S SIGNATURE <u>Edna Whittington</u>	24. FUNERAL DIRECTOR ADDRESS <u>R. A. PUMPHREY, 7557 Wisconsin Avenue, Bethesda, Maryland.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

DEPARTMENT OF HEALTH

U.S. GOVERNMENT PRINTING OFFICE

STATEMENT OF DEATH

THIS STATEMENT OF DEATH IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE DEATH.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

RECEIVED

MAY 3 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05015

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>White Oak</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodfield</u> TOWN <u>Woodfield</u> STREET ADDRESS (If rural, give location) <u>RFD #1 Gaithersburg</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Herbert</u> (Middle) <u>Charles</u> (Last) <u>King</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 5, 1932</u> 19 <u>yr.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>	11. BIRTHPLACE (State or foreign country) <u>Midland Texas</u>
13. FATHER'S NAME <u>William Oliver King</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Craft</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Wm. Oliver King, Gaithersburg, Md.</u>	
16. SOCIAL SECURITY No. <u>--</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Fracture of skull</u> Antecedent cause(s) (b) <u>823.5</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>170 c</u> <u>sudden death</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		PLACE (Home, farm, factory, street, office, etc.) <u>Highway</u> (CITY OR TOWN) <u>Silver Spring</u> (COUNTY) <u>Montg</u> (STATE) <u>md</u>	
TIME (Month) (Day) (Year) (Hour) <u>May 31-51</u> <u>4:00</u> <u>A</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Auto left highway</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>Frank J. Brownhart M.D.</u>		DATE SIGNED <u>5-31-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 2, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Wesley Grove</u>		LOCATION (City, town, or county) <u>Woodfield, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>6/1/51</u> <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>	

RECEIVED
JUN 4 1951
BUREAU N. S.

Reg. Dist. No. 223-

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH· COUNTY			2. USUAL RESIDENCE (HOME) OF DECEASED· STATE			COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town)			CITY (If outside corporate limits, write RURAL and give nearest town)			OR		
TOWN			TOWN			STREET ADDRESS (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX		
6. COLOR OR RACE			7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)			8. DATE OF BIRTH		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT AND ADDRESS		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause		(a) <u>Acute Congestive Cardiac Failure</u>								<u>Terminal</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u>		(b) <u>Hypertension</u>								<u>years?</u>			
		(c) <u>Arteriosclerosis</u>								<u>years?</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)				(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from <u>5/20/</u> , 19 <u>57</u> , to <u>5/20/</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/20/</u> , 19 <u>57</u> , and that death occurred at <u>1:35 a.m.</u> , from the causes and on the date stated above.													
SIGNATURE				(Degree or title)				ADDRESS				DATE SIGNED	
<u>Robert A. Hare</u>				<u>M.D.</u>				<u>Takoma Park, Md.</u>				<u>5/21/57</u>	
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county)		(State)			
		<u>5-23-57</u>		<u>MT Lebanon Cem.</u>				<u>Hyattsville</u>		<u>MD</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR				ADDRESS			
<u>5-25-57</u>		<u>J. William Dodd</u>				<u>B. Danzansky & son</u>				<u>Unk. DC</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 24 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8900 Manchester Rd</u>		STREET ADDRESS (If rural, give location) <u>8900 Manchester Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Estelle</u>	(Middle) <u>Maude</u>	(Last) <u>Lafferty</u>
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Oct. 15, 1875</u>
9. AGE last birthday <u>75</u> yrs.		10. DATE OF DEATH <u>May 24</u> 19 <u>57</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George L. Rice</u>		14. MOTHER'S MAIDEN NAME <u>L. Violet Walter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Hospital Records.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

Terminal

Antecedent cause(s)

(b)

Atherosclerosis2 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Diabetes Mellitus7 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Dermatitis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1941, to May 24, 1957, that I last saw the deceasedalive on May 22, 1957, and that death occurred at 12:25 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Robert A. Hare M.D. Takoma Park, Md. 5/24/57

5-28-57 Fort Lincoln Bladensburg, Md.

5/24/57 Frances Teller Deer Linnell Home 4812 Ga Ave

Wash DC

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05018

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>11500 Grandview Avenue</u>	
3. NAME OF DECEASED (First) <u>Bruce</u> (Middle) <u>Lee</u> (Last) <u>Langley</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Never</u>	8. DATE OF BIRTH <u>May 9-51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>1 day 2 hrs 40</u>
11. BIRTHPLACE (State or foreign country) <u>Suburban Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE LEE LANGLEY</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy ELIZABETH Laughlin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u></u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Prematurity

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not while At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/9, 1951, to 5/10, 1951, that I last saw the deceasedalive on 5/10, 1951, and that death occurred at 6:25 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

20509/23/313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 17 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05019

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>8906 Ewing Drive</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Ann</u> (Middle) <u>Elizabeth</u> (Last) <u>Lapham</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Jan. 24, 1940</u> 11 yrs.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Sacramento, Calif.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lloyd Lapham</u>		14. MOTHER'S MAIDEN NAME <u>Jean Elizabeth Joffee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) meningitis, streptococci, acute

INTERVAL BETWEEN ONSET AND DEATH

16 hrs?

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 May, 1951, to 21 May, 1951, that I last saw the deceased alive on 21 May, 1951, and that death occurred at 6:35 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Hubert Martyn MD.5029 Bethesda, Md21 May 51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

5-23-51Bessie M. ThompsonRobert A. Thompson, Bethesda, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Approved via phone
by Medical Examiner
Dr Broschart

Herbert M artyn f
MD

RECEIVED
APR 24 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dlst. No.

05020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hosp.</u>		STREET ADDRESS (If rural, give location) <u>6608 - 32nd. Pl. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u> (Middle) <u>Baynard</u> (Last) <u>Lister</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>14</u> (Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.X.X.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-4-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>natl. rifle assoc.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ex Director</u>	9. AGE last birthday <u>52 yrs.</u>	If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Wilmingtwn Del.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	13. FATHER'S NAME <u>James Lister</u>	
14. MOTHER'S MAIDEN NAME <u>Florence Carson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Army 1941</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Hospital Records.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>bronchopneumonia</u>			<u>4 days</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>glioblastoma of right temporal lobe</u>			<u>1 year</u>
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Dec. 14, 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>invading glioblastoma of right temporal lobe</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 20, 1957</u> , to <u>May 14, 1957</u> , that I last saw the deceased alive on <u>May 14, 1957</u> , and that death occurred at <u>11:10 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frederic Brennum M.D.</u>		DATE SIGNED <u>5/14/57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>5-17-57</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem</u>	LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
DATE REC'D BY LOCAL REG. <u>May 15/57</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>	ADDRESS <u>2901-14th St. N.W.</u>

290859

RECEIVED
MAY 17 1951
BUREAU A. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write OR give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>4504 Weland St.</u>	
3. NAME OF DECEASED (First) <u>Ursula</u> (Middle) <u>Beall</u> (Last) <u>Maphis</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 23, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>46</u> yrs. <u>46</u> Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Prince Georges Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Franklin Beall</u>		14. MOTHER'S MAIDEN NAME <u>Ella Virginia Meade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not Known</u>	
17. INFORMANT AND ADDRESS <u>Joseph Maphis</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

416X Immediate cause

(a) → Pulmonary Embolism - Rt lung - - -

INTERVAL BETWEEN ONSET AND DEATH

6 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral Embolism - Rt. Hemisphere.

36 hr.

(c) Rheumatic Heart Disease - 7 embolization + Hypertension 38 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 17 May, 1951, to 17 May, 1951, that I last saw the deceasedalive on 17 May, 1951, and that death occurred at 8:35 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-19-51</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron</u>		LOCATION (City, town, or county) <u>Winchester, Virginia</u> (State)	
DATE REC'D BY LOCAL REG. <u>5-20-51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05022

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>1938 North Courthouse Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Eiffel Thornton MATEER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 6 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4 April 1892</u>
9. AGE last birthday <u>59</u> yrs.		10. If under 1 year Months <u>1</u> Days <u>1</u> Hours <u>1</u> Mln. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not obtained</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Thornton MATEER</u>		14. MOTHER'S MAIDEN NAME <u>Alverna FOURTNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 5-23-18 to 4-8-19</u>		16. SOCIAL SECURITY NO. <u>4-8-19</u>	
17. INFORMANT AND ADDRESS <u>Wife: Rachel V. Mateer 1938 N. Courthouse Rd., Arlington, Va.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Infarction, Myocardium</u>			<u>4 days</u>
Antecedent cause(s) (b) <u>thrombosis, Coronary artery</u>			<u>4 days</u>
(c) <u>Arteriosclerotic heart disease</u>			<u>1 year</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3 May</u>, 19 <u>51</u> , to <u>6 May</u>, 19 <u>51</u> , that I last saw the deceased alive on <u>6 May</u>, 19 <u>51</u> , and that death occurred at <u>1026</u> P.m., from the causes and on the date stated above.			
SIGNATURE <u>S. W. Eyer</u>		ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
DATE SIGNED <u>6 May 1951</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 9, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u>		LOCATION (City, town, or county) (State) <u>Virginia</u>	
24. FUNERAL DIRECTOR <u>O.C. Pearson</u>		ADDRESS <u>412 Washington St. Falls Church, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>6 May 1951</u>		REGISTRAR'S SIGNATURE <u>Edith Whittington</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH
INVESTIGATION OF DEATH

RECEIVED

MAY 8 1951

BUREAU V. S.

" 18 " 6/26/51 ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05023

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Montgomery</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR give nearest town) <u>Sandy Springs</u>		CITY (If outside corporate limits, write OR give nearest town) <u>Sandy Springs</u>	
TOWN <u>Sandy Springs</u>		TOWN <u>Sandy Springs</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Bessie E. Matthews</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 23, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yrs. If under 1 year: Months <u>6</u> Days <u>29</u> Hours <u>15</u> Mins.
11. BIRTHPLACE (State or foreign country) <u>Montgomery, Maryland</u>		12. CITIZEN, OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Newman</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Ann Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Florence Evans (Daughter)</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebro vascular Embolism</u>		<u>4 weeks</u>
Antecedent cause(s) (b) <u>Probable Carcinoma (see over)</u>		<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hemiplegia</u>		<u>4 weeks</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive Cardio Renal disease</u>		
19a. DATE OF OPERATION <u>Hospitalized Suburban in Bethesda</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>X</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 20, 1951, to May 29, 1951, that I last saw the deceased alive on May 29, 1951, and that death occurred at 6 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Webster Sewell, M.D. ADDRESS Norfolk DATE SIGNED 6-2-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>6/2/51</u>	NAME OF CEMETERY OR CREMATORY <u>Sandy Springs</u>	LOCATION (City, town, or county) <u>Sandy Springs, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>6-2-51</u>	REGISTRAR'S SIGNATURE <u>Estimate B Lawler</u>	24. FUNERAL DIRECTOR <u>Chas. L. Swaden</u>	ADDRESS <u>Rockville</u>	

720826 and.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The probable carcinoma diagnosis was purely conjectural. 6-26-51 - ams.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05024

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> OR <u>8 days</u> LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> TOWN <u>4110 Fessenden St., N.W.</u> STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>			
3. NAME OF DECEASED (First) <u>Malcolm A.</u> (Middle) <u>Macdonald</u> (Last) <u>Macdonald</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>U.S. Gov.</u>	8. DATE OF BIRTH <u>1-1-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	9. AGE last birthday <u>60</u> yrs. <u>4</u> months <u>7</u> days <u>19</u> hours <u>51</u> min.
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Donald Macdonald</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Florence Piter Macdonald - wife</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>old.</u>
Immediate cause (a) <u>Myocardial Infarction</u>			
Antecedent cause(s) (b) <u>Myocarditis Pericarditis</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes Mellitus & Uremia</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? <u>While at Work</u> <input type="checkbox"/> <u>Not While at Work</u> <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>44</u> , to <u>May 22</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-22</u> , 19 <u>51</u> , and that death occurred at <u>9-55A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>P. P. Andrews M.D.</u>		ADDRESS <u>Washington D.C.</u>	
DATE SIGNED <u>5-22-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/25/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		LOCATION (City, town, or county) <u>Pr. George's Co. Md.</u>	
24. FUNERAL DIRECTOR <u>S.H. Hines Co. 2901 - 14th St. D.C.</u>			
DATE REC'D BY LOCAL REG. <u>5/23/51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

000916

RECEIVED
MAY 24 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05025

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>4201 East-West Highway</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Eleanor</u> (Middle) <u>Lavin</u> (Last) <u>McDowell</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>11-22-1883</u>
9. AGE last birthday <u>77</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. FATHER'S NAME <u>Jesse Hendrix</u>		13. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		15. SOCIAL SECURITY NO. <u>—</u>	
16. INFORMANT AND ADDRESS <u>Irene McKay - 4705 29th Pl. N.W. Wash.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

420.0

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

93d

(a) Coronary occlusion
(b) Arteriosclerotic heart disease
(c) with hypertension

INTERVAL BETWEEN ONSET AND DEATH

2 hours

3+ yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 49, 1949, to 11 May 51, 1951, that I last saw the deceased

alive on 11 May 51, 1951, and that death occurred at 10:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 5-14-51

REGISTRAR'S SIGNATURE

CO. FUNERAL DIRECTOR

ADDRESS

Bessie M. Thompson

W.H. Chamber. Co. 1400 Chapin St. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
MAY 16 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05026
2/3

1. PLACE OF DEATH- COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville		LENGTH OF STAY (In this place) 67 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5 North Adams Street				STREET ADDRESS 5 North Adams Street		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) Margaret		(Middle) V.		(Last) McFarland	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 11-4-1862	
						9. AGE last birthday 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Loudoun County, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George M. Fry				14. MOTHER'S MAIDEN NAME Ellen C. Stout			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Hattie B. McFarland-daughter-see /		Item 2	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral apoplexy

Antecedent cause(s)

(b)

Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

arterio-sclerosisII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN
ONSET AND DEATH**4 days**21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 27, 1951**, to **May 31, 1951**, that I last saw the deceasedalive on **May 30, 1951**, and that death occurred at **2 P.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Caryl Burbank M.D.**1801 E. St.****5.31.51**23. BURIAL, CREMATION
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-8-51**Helen S. Echeverde****Robert A. Humphrey****Bethesda, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AT

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05027

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223 -

1. PLACE OF DEATH - COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park</u>		LENGTH OF STAY (in this place) <u>23 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San + Hospital</u>				STREET ADDRESS (If rural, give location) <u>8207 Fenton St.</u>	
3. NAME OF DECEASED (Type or Print) <u>David</u>	(First)	(Middle) <u>None</u>	(Last) <u>Miller</u>	4. DATE OF DEATH <u>May 28</u>	(Month) (Day) (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>9-25-66</u>	9. AGE last birthday <u>84</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept of Justice</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Dunsmore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT AND ADDRESS <u>Miss Louise Miller 8207 Fenton St. SS. Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>
Antecedent cause(s) (b) <u>Papillary adenocarcinoma of Bladder</u>		<u>2 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Adenocarcinoma of Prostate</u>		<u>3 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cachexia + Incontinence</u>		<u>2 months</u>
19a. DATE OF OPERATION <u>1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Prostatectomy for adenocarcinoma of Prostate</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>u</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-5-, 1950, to 5-28, 1951, that I last saw the deceased alive on 5-28, 1951, and that death occurred at 9:30 m., from the causes and on the date stated above.

SIGNATURE <u>W. Shewalter</u>	(Degree or title)	ADDRESS <u>8005 Woodbury Drive Silver Spring, Md.</u>	DATE SIGNED <u>5/28/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Crementation</u>	DATE THEREOF <u>5/31/51</u>	NAME OF CEMETERY OR CREMATORY <u>Prince Geo. County</u>	LOCATION (City, town, or county) (State) <u>Md.</u>
DATE RECD BY LOCAL REG. <u>5-30-51</u>	REGISTRAR'S SIGNATURE <u>J. M. D. D.</u>	24. FUNERAL DIRECTOR <u>Wm. A. Humphrey</u>	ADDRESS <u>8434 Ga. Ave. Silver Spring, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05028

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
TOWN <u>Suburban</u>		TOWN <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural, give location) <u>3100 Connecticut Ave. N.W.</u>	
3. NAME OF DECEASED (First) <u>Farol</u> (Middle) <u>Marie</u> (Last) <u>Miller</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>30</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 13, 1900</u>
9. AGE last birthday <u>50</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Creumley</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>John W. Miller (husband)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Uremia2 weeks

Antecedent cause(s)

(b) Polycystic Kidney disease (bilateral)lifetime

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

renal hemorrhage & severe anemia

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb., 1949, to May 30, 1951, that I last saw the deceased alive on May 30, 1951, and that death occurred at 8:20 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>6-2-51</u>	<u>Brooksville Cem</u>	<u>Brooksville Fla.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6/1/51</u>	<u>Bessie M. Thompson</u>	<u>Deal Funeral Home</u>	<u>4812 1/2 La Grange Wash D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05029

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodfield Md</u> TOWN <u>2 weeks</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodfield Md</u> TOWN <u>2 weeks</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>ANNA</u> (Middle) <u>G</u> (Last) <u>MOYER</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> (Specify) <u>Masses</u>	8. DATE OF BIRTH <u>MAY 12 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Own Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John S. Gillies</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca H. Ricketts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Louise D. Moyer Woodfield Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

201X Immediate cause (a) Hodgkin's Disease

442 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 years.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JUNE 10, 1943, to MAY 1, 1951, that I last saw the deceased alive on APRIL 30, 1951, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

James J. Kerr M.D. Damascus, Md. 5/3/51

Bureau MAY 4 1951 East Lincoln Prince George Co Md

may 3, 1951 Della M. Burdette Ray W. Barker Leopoldville Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 4 1934

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

05030

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Damascus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Damascus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>RFD #5, Mt. Airy</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph H. Mullinix</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 19 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 29, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flour mill</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Mullinix, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John J. Mullinix</u>		14. MOTHER'S MAIDEN NAME <u>Emily Purdum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs Roscoe Purdum, Damascus, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial Insufficiency - Terminal

Antecedent cause(s)

Cardio-vascular-renal Disease with

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Inguinal hernia

19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION -----		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE <u>No</u> HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from December 27, 1950 to May 19, 1951, that I last saw the deceasedalive on May 19, 1951, and that death occurred at 7:10 p.m., from the causes and on the date stated above.SIGNATURE M. McKendree Boyer, M.D. (Degree or title) ADDRESS David Theatre Building, Damascus, Md. DATE SIGNED 5/21/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 22, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Damascus</u>		LOCATION (City, town, or county) (State) <u>Damascus Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 21, 1951</u>		REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>		24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

555409

RECEIVED
MAY 24 1981
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

05031

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Alexandria</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>700 Braxton Place</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John</u> <u>Sherman</u> <u>NIXON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 12,</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 31, 1913</u>
9. AGE last birthday <u>37</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ashton B. NIXON</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. WATSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>LWW II</u>		16. SOCIAL SECURITY No. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>Wife: Ruth E. NIXON</u>		18. MEDICAL CERTIFICATION Same as item # 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>196X Antecedent cause(s)</u> <u>556 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		<u>(a) SARCOMA, First, Second, and Third Thoracic Vertebra</u> <u>2 1/2 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 11, 1951</u> , to <u>May 12, 1951</u> , that I last saw the deceased alive on <u>May 12, 1951</u> , and that death occurred at <u>3:40 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>A. E. Marland</u>		ADDRESS <u>U.S. NAVAL HOSPITAL, BETHESDA, MD.</u>	
DATE SIGNED <u>May 13, 1951</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 15, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>May 13, 1951</u>		24. FUNERAL DIRECTOR <u>Cunningham Funeral Home, Alexandria, Virginia.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 15 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05032

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HYATTSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HYATTSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EDWARD LIVINGSTON NORWOOD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-18-1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8-25-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>AUCTIONEER</u>	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LORENZO B. NORWOOD</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH V. FLEMMING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>212-20-1319</u>	
17. INFORMANT <u>CARMYE F. NORWOOD</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a).....	<u>Cerebral hemorrhage</u>		<u>2 1/2 yrs.</u>
Antecedent cause(s) (b).....	<u>Arteriosclerosis</u>		<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Dec 5, 1948</u> , to <u>May 18, 1951</u> , that I last saw the deceased alive on <u>May 18, 1951</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Emmet P. Roop, M.D.</u>		ADDRESS <u>New Market, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5-20-1951</u>	NAME OF CEMETERY OR CREMATORY <u>PROSPECT</u>	LOCATION (City, town, or county) (State) <u>HYATTSTOWN MD.</u>
DATE REC'D BY LOCAL REG <u>5/19/51</u>	REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>	24. FUNERAL DIRECTOR <u>W. L. BURDETTE</u>	ADDRESS <u>HYATTSTOWN-MD.</u>

410808

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05033 214
Reg. Dist. No. 213-

1. PLACE OF DEATH COUNTY <u>Montgomery Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Coleville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
TOWN <u>College Park</u>		TOWN <u>College Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Home foraged</u>		STREET ADDRESS (If rural give location) <u>7206 Dartmouth Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Anna Elizabeth Oswald</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 7 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec 26, 1880</u>
9. AGE last birthday <u>71</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Washington Co, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Bernard F. Beck</u>		14. MOTHER'S MAIDEN NAME <u>Tamie Neff Huiette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Hosp. records</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pemphigus</u>	<u>2 wks</u>
Antecedent cause(s) (b) <u>Cerebral Arteriosclerosis</u>	<u>6 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) <u>None</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>
SUICIDE	INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <u>Work</u> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7 May, 1951, to 7 May, 1951, that I last saw the deceased alive on Never, 19—, and that death occurred at 6:40 p m., from the causes and on the date stated above.

SIGNATURE <u>Mertie J. White, M.D.</u>	DATE THEREOF <u>May 10, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Carlestown Cemetery</u>	LOCATION (City, town, or county) <u>Carlestown Md</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE REC'D BY LOCAL REG. <u>5/8/51</u>	REGISTRAR'S SIGNATURE <u>Amanda Danner</u>	24. FUNERAL DIRECTOR <u>J. Kraschinski</u>
5-9-51 (over)		ADDRESS <u>Hyattsville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

This patient has been under the care of Dr. John. Roger
since June 1950. I pronounced patient dead
while taking his calls.

7 May '51

Meritt L. White, MD -

RECEIVED
MAY 14 1951
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05034

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>Powell</u>	(Last) <u>Pierson</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	8. DATE OF BIRTH <u>6.10/10</u>	9. AGE last birthday <u>40</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Melvin Sylvester Powell</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME <u>Josephine Hackett</u>	
17. INFORMANT AND ADDRESS <u>Hospital records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Tuberculosis

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive cardiovascular renal disease(c) Rheumatic heart disease

INTERVAL BETWEEN ONSET AND DEATH

3 days8 yrs11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sy, 1949, to May, 1951, that I last saw the deceased alive on May 10, 1951, and that death occurred at 6:40 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. O. BonjantM.D.Sandy Spring, Md.5/11/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>5/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>	LOCATION (City, town, or county) (State) <u>Sandy Spring Md.</u>
DATE REC'D BY LOCAL REG. <u>5-14-51</u>	REGISTRAR'S SIGNATURE <u>William B. Lawler</u>	24. FUNERAL DIRECTOR <u>R. L. Anwarden</u>	ADDRESS <u>Rockville, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

720826

RECEIVED
MAY 18 1961
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05035

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural, give location) <u>3211 Ferndale St.</u>	
3. NAME OF DECEASED (First) <u>Dosola</u> (Middle) <u>Maria</u> (Last) <u>Poli</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Feb. 18, 1871</u>
9. AGE last birthday <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Bucca, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ricci</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Pneumonia</u>		<u>Bilateral type pneumonia (7 days)</u>	
Antecedent cause(s) (b) <u>450.0 Congestive Heart Failure</u>		<u>(1 month)</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>108 Arteriosclerosis, Generalized</u>		<u>(yrs)</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr. 15, 1951</u> , to <u>5/4/51</u> , 19....., that I last saw the deceased alive on <u>5/3/51</u> , 19....., and that death occurred at <u>10:55 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Samuel Miller M.D.</u>		ADDRESS <u>Kensington Md</u>	
DATE SIGNED <u>5/4/51</u>			
23. (BURIAL) CREMATION REMOVAL (Specify) <u>5-7-51</u>		NAME OF CEMETERY OR CREMATORY <u>Int. Olivet Cem.</u>	
DATE REC'D BY LOCAL REG. <u>5-5-51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Co</u>		ADDRESS <u>2901 14th St NW</u>	
		WASHINGTON D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

05036

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Damascus		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Damascus	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) Hepsie (Middle) Gertrude (Last) Poole		4. DATE OF DEATH (Month) May (Day) 15 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 2, 1875
9. AGE last birthday 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Columbus Purdum		14. MOTHER'S MAIDEN NAME Amanda Warfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Roger F. Poole, Damascus, Md.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Arteriosclerotic cardiovascular disease		10 years	
Antecedent cause(s) (b) 4221 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d			
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia		2 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 20, 1941 , to May 15, 1951 , that I last saw the deceased alive on May 15, 1951 , and that death occurred at 9:00 p.m. , from the causes and on the date stated above.			
SIGNATURE James P. Kerr M.D.		ADDRESS Damascus, Md.	
DATE SIGNED 5/17/51			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF May 18, 1951	
NAME OF CEMETERY OR CREMATORY Providence		LOCATION (City, town, or county) (State) Kenptown, Maryland.	
DATE REC'D BY LOCAL REGISTRY May 17, 1951		REGISTRAR'S SIGNATURE Della N. Burdette	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 21 1961
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05037

Items 8, 9 on:

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write BUREAU and give nearest town) Takoma Park LENGTH OF STAY (in this case) 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. San. Hosp.
2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY Montg.
CITY (If outside corporate limits, write BUREAU and give nearest town) Takoma Park
STREET ADDRESS (If rural, give location) 114 Park Ave
3. NAME OF DECEASED (First) (Middle) (Last) Mary Magdalene Rea
4. DATE OF DEATH (Month) (Day) (Year) May 1 1951
5. SEX Female 6. COLOR OF RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 11-20-78 9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Nashville Tenn 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John C. Mattimore 14. MOTHER'S MAIDEN NAME Catherine Kelly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY No. 1-1-51 17. INFORMANT AND ADDRESS Wash San Hosp

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Broncho pneumonia - Intermittent over

INTERVAL BETWEEN ONSET AND DEATH 35 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Uremia -
(c) Ch. Deg. Myocarditis Arr. fibrillation

6 day
about
1 1/2 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

Diabetes Mellitus

?

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21. ACCIDENT (Specify) None PLACE (Home, farm, factory, street, office-bldg., etc.) None (CITY OR TOWN) None (COUNTY) None (STATE) None
TIME (Month) (Day) (Year) (Hour) OF INJURY None INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from 10/17, 1950, to 5/1, 1951, that I last saw the deceased alive on May 1, 1951, and that death occurred at 8:30 a.m., from the causes and on the date stated above.
SIGNATURE Howard I. Moore (Degree or title) MD ADDRESS 28 Carroll Ave. Takoma Park Md DATE SIGNED 5/1/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF May 4, 1951 NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery LOCATION (City, town, or county) Washington (State) D.C.
DATE REC'D BY LOCAL REG. 5-1-51 REGISTRAR'S SIGNATURE J. Arthur Walters 24. FUNERAL DIRECTOR J. Arthur Walters ADDRESS 234 Carroll St NW Washington DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05038

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>218 W. Montgomery Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Wena</u> (Middle) <u>Ricketts</u> (Last) <u>W. Montgomery</u>	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 2, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wallace E. Ricketts</u>		14. MOTHER'S MAIDEN NAME <u>Emma L. Mullican</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Estelle Hartley-Rockville, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Toxemia

INTERVAL BETWEEN ONSET AND DEATH

40 hrs

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

mechanical obstruction10 days

(c)

adhesions18 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

postoperative ileus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4:24:57, 1951, to 5:2:57, 1951, that I last saw the deceasedalive on 5-1-57, 1951, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 5/4/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial5 May 1951Rockville UnionRockville, Montg. Md.Beattie M. ThompsonRobert A. Humphrey Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15

093886

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05039

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Olney		CITY (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County General Hospital, Inc., Olney, Md.		STREET ADDRESS Route 2 (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Mary V. Ross		4. DATE OF DEATH (Month) May (Day) 11 (Year) 19 51	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED , DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 26, 1876
9. AGE last birthday 74 yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Stewart		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Frazier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Record	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Distal Coronary	2 days
Antecedent cause(s) (b) Diabetes	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Operated on for Incurable mitral / aortic	
19a. DATE OF OPERATION 5/3/51	19b. MAJOR FINDINGS OF OPERATION Incurable mitral / aortic
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY 5/3/51	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **5/3/51**, 19**51**, to **5/11/51**, 19**51**, that I last saw the deceased alive on **5/11/51**, 19**51**, and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

SIGNATURE **James M. Sander** (Degree or title) ADDRESS **Rockville, Md.** DATE SIGNED **5/12/51**

23. BURIAL CREMATION REMOVAL (Specify) 5/15/51	DATE THEREOF 5/15/51	NAME OF CEMETERY OR CREMATORY Brooke Grove	LOCATION (City, town, or county) (State) Rockville, Md.
DATE REC'D BY LOCAL REG. 5-15-51	REGISTRAR'S SIGNATURE Bertrude B. Lawler	24. FUNERAL DIRECTOR R. L. Snavden	ADDRESS Rockville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1961
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05040

Reg. Dist. No. 218

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grantham</u> TOWN <u>Grantham</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F. J.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>mt. airy</u> TOWN <u>mt. airy</u> STREET ADDRESS <u>rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Raymond</u> (First) <u>Bunkles</u> (Middle) <u>Bunkles</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 1, 1888</u>
9. AGE last birthday <u>63</u> years <u>4</u> months <u>1</u> day		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer day work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William O Bunkles</u>		14. MOTHER'S MAIDEN NAME <u>Adrian Pihon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>213-36-3027</u>	
17. INFORMANT AND ADDRESS <u>Myrtle S Bunkles</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>coronary occlusion</u>	<u>sudden</u>
Antecedent cause(s) (b) <u>420.1</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>death</u>
(c) <u>94a</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) Frank J. Brumhart M.D. ADDRESS Grantham md DATE SIGNED 5-17-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 20, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cloppersville</u>	LOCATION (City, town, or county) <u>Montgomery Co md</u>
DATE REC'D BY LOCAL REG. <u>May 20, 1951</u>	REGISTRAR'S SIGNATURE <u>Abner L. Cooke</u>	24. FUNERAL DIRECTOR <u>Roy W. Barber</u>	ADDRESS <u>Leptonsville</u>

970346 mg

RECEIVED

MAY 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05041

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA #14</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#7E. Cedar Lane</u>		STREET ADDRESS (If rural, give location) <u>#7 EAST Cedar Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH REESIDE SCANTLING</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>DEC 20 1888</u>
9. AGE last birthday <u>62 yrs.</u>		10. If under 1 year: Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DENNISON Reeside</u>		14. MOTHER'S MAIDEN NAME <u>SACHAEL ARMOR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT AND ADDRESS <u>MR. J. CARTLEY D. REESIDE 9101-14th St. Rd.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic congestive heart failure due to</u>			<u>5 yrs</u>
Antecedent cause(s) (b) <u>Arteriosclerosis and</u>			<u>10+ years</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>			<u>10+ years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Right hemiplegia with residual complete right sided paralysis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 3, 1950</u> , to <u>May 15, 1951</u> , that I last saw the deceased alive on <u>May 14, 1951</u> , and that death occurred at <u>4:10 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>R. Stephen Hulbert, M.D.</u>		ADDRESS <u>3000 Cent Pl. NW Wash D.C.</u> DATE SIGNED <u>May 15 1951</u>	
23. BURIAL/CREMATION REMOVAL (Specify) <u>5/18/51</u>		NAME OF CEMETERY OR CREMATORY <u>OAK Hill Cem</u> LOCATION (City, town, or county) <u>WASH. D.C.</u> (State)	
DATE REC'D BY LOCAL REG. <u>5-15-51</u>		REGISTRAR'S SIGNATURE <u>Bessie W. Thompson</u>	
24. FUNERAL DIRECTOR <u>The A. H. Harris Co.</u>		ADDRESS <u>2901-14th St. NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

390916

RECEIVED
MAY 17 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05042

Reg. Dist. No. 228

1. PLACE OF DEATH COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lakewood Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. & Hosp.</u>		STREET ADDRESS <u>9141 Shigo Creek Highway</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Robert Susan Schoffestall</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-9-26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student & part time painter</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>24</u> yrs. <u>24</u> Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Wash. DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Schoffestall</u>		14. MOTHER'S MAIDEN NAME <u>Lorraine Susan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW II</u>	
17. INFORMANT AND ADDRESS <u>Hosp. records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>Cerebral lacunaritis & subdural</u>			
Antecedent cause(s) <u>hemorrhage and Rt Thoracic hemorrhage</u>			
Disease or conditions, if any, giving rise to the above cause <u>due to crushed chest</u>			
stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office, hldg., etc.) OF INJURY <u>Building</u>	(CITY OR TOWN) <u>Silver Spring</u>	(COUNTY) <u>Montgomery</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 15-51 P.M.</u>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell from roof</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Frank J. Burchart M.D.</u>		DATE SIGNED <u>5-16-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/18/51</u>	<u>Arlington National Cemetery</u>	<u>Arlington, Virginia</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5-17-57</u>	<u>J. William Dodd</u>	<u>Wm. W. Pumphrey</u>	<u>8434 Georgia Ave. Silver Spring, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 21 1961
BUREAU A. I.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

05351

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Nr. Seneca</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Seneca. Maryland</u>		STREET ADDRESS (If rural, give location) <u>Nat. Institute of Health</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mark</u>	(Middle) <u>Perry</u>	(Last) <u>Schultz</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>26</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-4, 1899</u>
9. AGE last birthday <u>51</u> yrs.	If under 1 year <u>6</u> Months	If under 24 hrs <u>6</u> Days	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr. U.S. Public Health</u>
11. BIRTHPLACE (State or foreign country) <u>Oxford, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Orange W. Schultz</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Owens</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>1410 - 16th St., N.W. Ruth P. Schultz - Washington, D. C.</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Undetermined - Found dead in woods -</u>			
Antecedent cause(s) (b) <u>Had been missing since May 26, 1951</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> .			
SIGNATURE <u>Frank J. Broschart M.D.</u>		DATE SIGNED <u>10-6-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>10-8-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>
DATE REC'D BY LOCAL REG. <u>10/9/51</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 11 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05043

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In Transit to Hosp</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Mont-</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring - Md</u> TOWN STREET ADDRESS (If rural, give location) <u>9930 Markham St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Wesley Middleton Skillman</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1957</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 21, 1878</u>		9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Government, War Department</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Enos Ayres Skillman</u>		14. MOTHER'S MAIDEN NAME <u>Alice Middleton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Ada P. Skillman, 9930 Markham St.</u>		18. MEDICAL CERTIFICATION <u>Silver Spring, Md.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Sodium Fluoride poisoning</u>						?	
Antecedent cause(s) (b) <u>1635</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Burchard M.D.</u>				ADDRESS <u>Yeastbury Md</u>		DATE SIGNED <u>5-10-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/12/57</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REG. <u>5-12-57</u>		REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u>		24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u>		ADDRESS <u>8434 Ga. Ave., Silver Spring, Maryland</u>	

BUREAU A. B.
MAY 13 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05044

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Deerwood Md</u> TOWN <u>all life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Deerwood Md</u> TOWN <u>all life</u> STREET ADDRESS (If rural, give location) <u>-</u>			
3. NAME OF DECEASED (First) <u>JOHN</u>		(Middle) <u>HENRY</u>		(Last) <u>SMITH</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 1, 1872</u>	9. AGE last birthday <u>79</u> yrs.	If under 1 year Months <u>7</u> Days <u>7</u>		If under 24 hrs. Hours <u>7</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor day work on farm</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George Smith</u>				14. MOTHER'S MAIDEN NAME <u>Louise Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT AND ADDRESS <u>Malinda Russell Deerwood Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH <u>1 we</u> <u>year</u>	
Immediate cause (a) <u>Uremia</u>		Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Disease</u>					
443X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>1950</u> , 1950, to <u>5/7</u> , 1951, that I last saw the deceased alive on <u>5/4</u> , 1951, and that death occurred at <u>2-30</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Sandy Spring, Md.</u>		DATE SIGNED <u>5/9/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 17, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mt Md</u>		LOCATION (City, town, or county) (State) <u>Montgomery Co Md</u>	
DATE REC'D BY LOCAL REG. <u>5/9/51</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Roy W. Bashford</u>		ADDRESS <u>Leopoldville Md</u>	

820105

RECEIVED
MAY 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

05045

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY Fairfax	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Falls Church	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 704 Poplar Drive	
3. NAME OF DECEASED (Type or Print) Gladys Elizabeth STAPP		4. DATE OF DEATH (Month) May (Day) 29 (Year) 19 51	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb 6, 1920
9. AGE last birthday 31 yrs.		10. If under 1 year: Months 03 Days 23 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10h. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John W. WATTS		14. MOTHER'S MAIDEN NAME Lucy Ann GALLAWAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY No. - - - - -	
17. INFORMANT AND ADDRESS Husband: John B. STAPP			

18. MEDICAL CERTIFICATION **Same as item # 2**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Port Partum Hemorrhage	4 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Uterine atony	4 hrs.
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 25**, 19**51**, to **May 29**, 19**51**, that I last saw the deceasedalive on **May 29**, 19**51**, and that death occurred at **5:00 A** m., from the causes and on the date stated above.SIGNATURE **L. M. HARRIS, CAPTAIN, MC, USN** U.S. NAVAL HOSPITAL, BETHESDA, MD. **May 29, 1951**

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 1, 1951	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) (State) Arlington, Virginia
DATE REC'D BY LOCAL REG May 29, 1951	REGISTRAR'S SIGNATURE Elith Whittington	24. FUNERAL DIRECTOR S. H. Hines Funeral Home, 2901 14th St., N.W., Washington, D.C.	ADDRESS 2588 Smith

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 31 1951
BUREAU V. S.

RECEIVED
MAY 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

05047

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. & Hospital</u>		STREET ADDRESS (If rural, give location) <u>9613 Warren Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Clara</u> (First)	<u>Virginia</u> (Middle)	<u>Stubbbs</u> (Last)	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>22</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>4-3-1860</u>
9. AGE last birthday <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Ball</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Pt. Chart</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Hypertensive pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Fracture of Hip Right

(c)

Hypertension

INTERVAL BETWEEN ONSET AND DEATH

7 days8 mo's10 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>acc.</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>S.S.</u>	(COUNTY) <u>Mont.</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9/29/50</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Fell from chair.</u>		

22. I hereby certify that I attended the deceased from 5/17, 1957, to 5/23, 1957, that I last saw the deceasedalive on 5/22, 1957, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-25-1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	LOCATION (City, town, or county) <u>Forest Glen</u>	(State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>5-23-51</u>	REGISTRAR'S SIGNATURE <u>J. H. M. [Signature]</u>	24. FUNERAL DIRECTOR'S ADDRESS <u>Robert A. Humphrey Bethesda, Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Inf re accident from Dept of Exam.
6/2/51

BUREAU U. S.

MAY 28 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05048

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Washington, D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rest Home-Friendship</u>		STREET ADDRESS (If rural, give location) <u>5336 Colo. Ave. N.W.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Kate</u> (Middle) <u>H.</u> (Last) <u>Swart</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>19</u> (Year) <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>8/6/1859</u>
9. AGE last birthday <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>	
13. FATHER'S NAME <u>John McChesney</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mary King</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Grace Sigourney 5321 Colo Ave. NW, DC</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Myocardial degeneration with acute heart failure

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/11, 1951, to 5/19, 1951, that I last saw the deceased alive on 5/19, 1951, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>5/22/51</u>	NAME OF CEMETERY OR CREMATORY <u>Lock Creek Cem.</u>	LOCATION (City, town, or county) <u>Washington, DC</u>	(State)
DATE REC'D BY LOCAL REG. <u>5/21/51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>S. H. Hines Co. 2901 14th St. NW, D.C.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05049

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
TOWN <u>Suburban Hosp.</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural, give location) <u>214 Wilson Lane</u>	
3. NAME OF DECEASED (First) <u>David</u> (Middle) <u>Wloyd</u> (Last) <u>Taxis</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>XXX</u>	8. DATE OF BIRTH <u>Oct. 17, 1948</u>
9. AGE last birthday <u>2</u> yrs. <u>8</u> Months <u>26</u> Days		10. If under 1 year <u>8</u> Months <u>26</u> Days	
11. BIRTHPLACE (State or foreign country) <u>Bridgeton, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Otto Taxis</u>		14. MOTHER'S MAIDEN NAME <u>Doris Chew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>XX</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Sub acute meningitis - prob. influenza 3 wks.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) pneumonitis

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

May 2, 1951

19b. MAJOR FINDINGS OF OPERATION

meningeal block

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) HOMICIDE (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 5-13-51 INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-15, 1951, to 5-13, 1951, that I last saw the deceased

alive on 5-13, 1951, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE John M. Humphrey (Degree or title) ADDRESS Bethesda, Maryland DATE SIGNED 5-13-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial - Transit DATE THEREOF 5-15-51 NAME OF CEMETERY OR CREMATORY Overlook Cemetery LOCATION (City, town, or county) Bridgeton, New Jersey (State) New Jersey

DATE REC'D BY LOCAL REG. 5-14-51 REGISTRAR'S SIGNATURE Bessie M. Thompson 24. FUNERAL DIRECTOR Robert W. Humphrey ADDRESS Bethesda, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05050

Reg. Dist. No. 223

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sligo Creek at Cornell Ave</u>		STREET ADDRESS <u>7204 14th Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Esther Clark</u> (First) <u>Terry</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-11-1911</u>
9. AGE last birthday <u>39</u> yrs.		10. If under 1 year: Months <u>1</u> Days <u>22</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jama S Clark</u>		14. MOTHER'S MAIDEN NAME <u>Edith Clawson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Edward H Terry (husband)</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

978X Immediate cause (a) Internal hemorrhage due to

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

1642

(b) Crushed chest

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing in the death but not related to the disease or condition causing death.

Comp fracture of ankle - fracture left arm

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Nt while at work ☐

HOW DID INJURY OCCUR?

Jumped from bridge

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Cremation

5/23/51

Rt. Lincoln Crematory

Prince Geo. County

Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-23-51

J. William Dodd

Werner B. Humphrey

8434 Georgia Ave.

Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05051

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Clagettsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Clagettsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Monrovia, Md. R.F.D.# 2</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Vedah</u>	<u>Blanche</u>	<u>Thompson</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>May</u>	<u>5</u>	<u>1951</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>April 15, 1890</u>
9. AGE last birthday	If under 1 year	If under 24 hrs.	If under 1 year
<u>61</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>	<u>Own home</u>	<u>Lewisdale, Md.</u>	<u>USA</u>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<u>Willian Beall</u>	<u>Virginia Watkins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS	
<u>no</u>	<u>none</u>	<u>Elmer Thompson, Monrovia, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>			<u>1 hour</u>
Antecedent cause(s) (b) <u>Arteriosclerotic cardiovascular disease</u>			<u>8 years</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 10, 1943</u> , to <u>May 5, 1951</u> , that I last saw the deceased alive on <u>January 10, 1951</u> , and that death occurred at <u>10:50 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE		(Degree or title)	ADDRESS
<u>James B. Kerr</u>		<u>M.D.</u>	<u>Damascus, Md.</u>
DATE SIGNED		<u>May 7, 1951</u>	
23. BURIAL, CREMATION, REINTERMENT (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 8, 1951</u>	<u>Montgomery Church</u>	<u>Clagettsville, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 7, 1951</u>	<u>Della W. Burdette</u>	<u>Olin L. Molesworth</u>	<u>Damascus, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 9 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05052

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 East Thornapple St.</u>		STREET ADDRESS (If rural, give location) <u>9 East Thornapple St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hettie</u>	(Middle) <u>Preston</u>	(Last) <u>Tyson</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>1</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>16 Feb 1855</u>
9. AGE last birthday <u>96</u> yrs.		10. If under 1 year Months <u>2</u> Days <u>14</u> If under 24 hrs. Hours <u>11</u> Mins. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XXXX</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. ?</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hallar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Hettie P. Haydon</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>Emaciation & inanition</u>		<u>6+ wks.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Senility</u>		<u>3+ yrs.</u>
Patient had or was: 1. Almost totally deaf 2. Mixed arthritis, rather marked 3. Myocarditis, but it was not typical cardiac death 4. Paresis mouth & throat muscles, making eating and expectoration difficult. (5/7/51 akc)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 46, 1946 to May 51, 1951, that I last saw the deceased alive on 30 Apr 1951, and that death occurred at 8:50 a.m., from the causes and on the date stated above.

SIGNATURE <u>W. A. Richwine, Md.</u>	(Degree or title)	ADDRESS <u>5522 Western Ave Chch. Md.</u>	DATE SIGNED <u>May 51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet-Frederick</u>	LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
DATE REC'D BY LOCAL REG. <u>5-1-51</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05053

Reg. Dist. No. 217

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Brookville</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>	
TOWN <u>Brookeville</u>		TOWN <u>Brookville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>EVA</u>	(First) <u>E</u> (Middle) <u>WEBER</u> (Last)	4. DATE OF DEATH <u>MAY 13 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec 19 - 1894</u>
9. AGE last birthday <u>58</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Adrian Matulovich</u>	14. MOTHER'S MAIDEN NAME <u>Jenni Nazornowsky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mrs. Lynn Douns Brookeville</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Hemorrhage</u>	Interval <u>Immediate</u>	
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio-vascular-renal disease</u>	<u>6 months.</u>	
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/14, 1951, to 5/13, 1951, that I last saw the deceased alive on 5/5, 1951, and that death occurred at 3:15 P.m., from the causes and on the date stated above.

SIGNATURE Rubad A. Yates M.D. (Degree or title) ADDRESS Olney, Md. DATE SIGNED 5/13/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>May 16 - 1951</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore City</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>5-15-51</u>	REGISTRAR'S SIGNATURE <u>Arthur B. Zander</u>	24. FUNERAL DIRECTOR <u>W. Barber & Son</u>	ADDRESS <u>Gettysburg</u>	

390916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MAILED 10 21 1951

10 21 1951

10 21 1951



RECEIVED
OCT 21 1951
U.S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05054

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
TOWN <u>Takoma Park</u>		TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium + Hospital</u>		STREET ADDRESS (If rural, give location) <u>630 Farragut St. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>Jennie</u>		4. DATE OF DEATH <u>5-11-1951</u>	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>8-12-73</u>	
9. AGE last birthday <u>77</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Alexander Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Martha Beach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

153X

Antecedent cause(s)

462

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Adenocarcinoma - Sigmoid - C. Esophagus
 (b) metastasis
 (c) Cerebral Thrombosis
Terminal Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

5 years

10 days

3 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>July 1947</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large sigmoid S. & L. cancer of the colon</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July, 1947, to 5-11, 1951, that I last saw the deceasedalive on 5-11, 1951, and that death occurred at 4:55A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/14/51</u>		NAME OF CEMETERY OR CREMATORY <u>Fairfax</u>		LOCATION (City, town, or county) <u>Fairfax Va</u>		(State)	
DATE RECD BY LOCAL REG. <u>5/12/51</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Jerry Lee Jones Co</u>		ADDRESS <u>300-4th St NE Wash. DC</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 15 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05055

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>MD - B2 Mont.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Washington</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>College Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>W.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jolliff Nursing Home</u>		STREET ADDRESS (If rural give location) <u>325 Bryant St. N.E.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Thomas Edmund White</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 3, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov 3 1862</u>
9. AGE last birthday <u>88</u> yrs.		10. Under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Federalburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Warhill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Mary M. Wilcox</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>331X Antecedent cause(s)</u>	(a) <u>Massive Cerebral Hemorrhage</u>	<u>3 hrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized arteriosclerosis</u>	<u>3 yrs.</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-2, 1951, to 5-3, 1951, that I last saw the deceased alive on 5-3, 1951, and that death occurred at 4:40 p.m., from the causes and on the date stated above.

SIGNATURE <u>Robert M. D.</u>		ADDRESS <u>1805 Lanning Rd. Lil. Sp. Md.</u>		DATE SIGNED <u>5-3-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>5-7-51</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	LOCATION (City, town, or county)	(State)	
DATE REC'D BY LOCAL REG. <u>May 4/51</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>The S. H. Huns</u>	ADDRESS <u>202901-14th St N.E. Wash. D.C.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>Hotel Cairo (16th & Q Sts., NW)</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>John Arthur WILHELM</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 23, 1872</u>
9. AGE last birthday <u>78</u> yrs.		10. If under 1 year Months <u>09</u> Days <u>29</u>	11. If under 24 hrs. Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Enlisted Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Marine Corps</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>US(N)</u>	
13. FATHER'S NAME <u>Demil WILHELM</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy LOEIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT AND ADDRESS <u>U.S. Marine Corps Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

5 hours

Antecedent cause(s)

(b)

Arteriosclerotic Heart Disease10 yrs

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY
m.INJURY OCCURRED
While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1951, to May 22, 1951, that I last saw the deceasedalive on May 22, 1951, and that death occurred at 5:35 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. W. FLYNN, LTJG MC, USNU.S. NAVAL HOSPITAL, BETHESDA, MD. May 24, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialMay 28, 1951Arlington NationalArlington, Virginia

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 24, 1951Edith WhittingtonWastley Funeral Home, 301 East Capitol Street, Washington, D.C.

595416

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

05057

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Indiana</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Marchand, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED (First) <u>Bertha</u> (Middle) <u>Maude</u> (Last) <u>WINEBERG</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 26, 1880</u>
9. AGE last birthday <u>70 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Sidney PEPPER</u>		14. MOTHER'S MAIDEN NAME <u>Anna HALDERMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Son: Charles R. WINEBERG, 7310 Martell Ave., Baltimore, Maryland</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hemorrhage, IntracerebralAntecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Leukemia, Lymphocytic, Chronic

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 28, 1951, to May 10, 1951, that I last saw the deceased alive on May 10, 1951, and that death occurred at 6:48 P. m., from the causes and on the date stated above.

SIGNATURE: R. J. MC CARTHY

(Degree or title)

ADDRESS

DATE SIGNED

R. J. MC CARTHY, LT, MC, USN

U.S. NAVAL HOSPITAL, Beth., Md.

May 11, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>May 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Marchand Cemetery</u>	LOCATION (City, town, or county) <u>Marchand, Pennsylvania</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 11, 1951</u>	REGISTRAR'S SIGNATURE <u>Edith W. Wittington</u>	24. FUNERAL DIRECTOR <u>Chevy-Chase Funeral Home, 5101 Wisconsin Avenue, NW, Washington, D.C.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 15 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

05058

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Dist of Col</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5012 21st Ave.</u>		STREET ADDRESS (If rural, give location) <u>3911 Morrison St NW</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Carter Wingfield</u>		4. DATE OF DEATH <u>May 9</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <u>SINGLE, MARRIED, WIDOWED, DIVORCED</u> (Specify)	8. DATE OF BIRTH <u>Feb 77 1968</u> 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balt. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William D. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs Virginia H Sharpe</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Hypertensive Heart Disease.

INTERVAL BETWEEN ONSET AND DEATH

10 415

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Arteriosclerosis10 96

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Age.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940, 1951, to 5/9, 1951, that I last saw the deceasedalive on 5/5, 1951, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 10/51Francis LittleCherry Chase Funeral Home5103 21st AveWash D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 14 1951
DEPT. V. S.